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Achieving Optimal Volition and Well-Being: Facilitating Movement Along the Motivational Continuum Through Self-Determination Theory

Andrew Thompson

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Achieving Optimal Volition and Well-Being: Facilitating Movement Along the Motivational
Continuum Through Self-Determination Theory

by

Andrew Thompson

A Banded Dissertation in Partial Fulfillment
of the Requirements for the Degree
Doctor of Social Work

St. Catherine University | University of St. Thomas
School of Social Work

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Abstract

The dissertation comprises three products that considered self-determination theory (SDT) as theoretical framework to support interventions that promote satisfaction of basic psychological needs among recipients of assertive community treatment (ACT) and forensic assertive community treatment (FACT). The first product is a paper that conceptualized and integrated elements of self-determination (autonomy, competence, and relatedness) in the implementation of assertive community treatment and forensic assertive community treatment. The integration of implementation of these basic psychological needs provided a framework to increase autonomy and self-determination, which has proven effective at increasing enhanced client wellness and optimal outcomes. The second product is a cross-sectional exploratory study of ACT and FACT participants ($n = 100$), between 21 and 67 years of age ($M = 42.23$, $SD = 12.74$), who had between five and 16 years of education ($M = 12.05$, $SD = 1.87$), and were on the ACT team for an average of approximately four and a half years ($M = 4.05$, $SD = 3.33$). The study examined relationships between basic psychological needs construed from the lens of self-determination theory and overall client satisfaction with services. Findings showed that, satisfaction positively and significantly correlated with relatedness, $r = .45$, 95% $CI [.28, .59]$, $p < .001$, and autonomy, $r = .33$, 95% $CI [.14, .49]$, $p = .001$, both of which were medium in effect size (Cohen, 1992). A statistically significant positive correlation was also found between satisfaction and competence, $r = .24$, 95% $CI [.05, .42]$, $p = .015$, which was small-to-medium in effect size. The correlations between competence, autonomy, and relatedness were positive and statistically significant ($p < .05$). Further, findings from a multiple regression showed that *relatedness* is a significant predictor of satisfaction ($R^2 = .22$, $F(3, 96) = 8.80$, $p < .05$). The third product is an annotated overview of a peer-reviewed presentation entitled *Promoting Smart Decarceration Through*

Forensic Assertive Community Treatment presented at the Council on Social Work Education's (CSWE) 63rd Annual Program Meeting (APM) entitled *Educating for the Social Work Grand Challenges*. The overview includes analysis and presentation of research from the conceptual paper and findings from the cross-sectional exploratory study.

Keywords: self-determination theory, assertive community treatment, smart decarceration, client satisfaction

Dedication/Acknowledgments

I would like to thank my partner Clarissa for offering her patience, understanding, and support throughout this process, which has often led to sacrifices of countless social endeavors over the last few years. I am appreciative and thankful for the support I have received from my family. I also owe an extreme amount of gratitude to my advisor, Dr. Kingsley Chigbu, who has generously dedicated his time, support, and mentorship which has far exceeded what could normally be expected of the average human being.

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Achieving Optimal Volition and Well-Being: Facilitating Movement Along the Motivational
Continuum Through Self-Determination Theory

The focus of this banded dissertation is on assertive community treatment (ACT), forensic assertive community treatment (FACT), the use of coercion in practice interventions, and the role of the social worker in upholding a client's self-determination in mental health and criminal justice practice settings. Assertive community treatment (ACT) is a multidisciplinary evidence-based community service model that is designed to serve individuals who are diagnosed with one or more serious and persistent mental illnesses (SPMI) as well as co-occurring disorders (Allness & Knoedler, 2003). Forensic assertive community treatment (FACT) is designed specifically to serve justice-involved clients and actively partner with the criminal justice system by means of coordination of care throughout the discharge planning process as well as active partnership with the client's probation officer (Lamberti, Weisman, & Faden, 2004). Specifically, ACT/FACT practices are conceptualized and examined from the lens of the self-determination theory (SDT). This includes an analysis of the range of coercive practice interventions utilized in these practice settings, and how the application of SDT can address interventions that interfere with client self-determination and autonomy.

There are many aspects of the ACT model of care that involve the deliberate use of coercion, which is not aligned with a recovery-based orientation (Drake & Deegan, 2008). The original ACT model was designed to be time-unlimited in duration, which means that a person could be on an ACT team their entire life (Stein & Test, 1980). This time-unlimited approach has more recently been revisited and replaced with a recovery-oriented approach that recognizes growth and recovery, which can include successful discharge and transition to lower levels of care (Finnerty et al., 2015). The self-determination theory provides a conceptual framework for

empirically supported interventions such as ACT and FACT by means of satisfying SDT's basic psychological principles of autonomy, competence, and relatedness (Deci & Ryan, 2008). SDT is an empirically validated theory of human motivation, which can serve as a framework to help individuals move along the continuum of care, regardless of the persons' type of motivation, whether it be intrinsic or extrinsic (Deci, Olafsen, & Ryan, 2016).

Many of the critiques of the ACT model of care reference the types of interventions that are often experienced as coercive by client, such as medication adherence strategies, payeeship, civil commitment, or use of legal leverage (Diamond, 1996; Fisher & Ahern, 2000; Gomory, 1999, 2001; Kirk, Gomory, & Cohen, 2013; Spindel & Nugent, 2000). SDT suggests that externally regulated interventions can eventually be internalized and experienced as authentic as clients begin to take greater ownership of their treatment experiences (Deci & Ryan, 2008). The FACT emerging model of care poses additional complications as it involves an active partnership with probation or parole officers. This could pose challenges for social workers, as these entities often use coercive intervention practices, such as threats of incarceration, as a means to hold clients accountable to treatment adherence. It is critical to assess the philosophical implications of integrating social work practice with criminal justice practice methods. Social workers in this practice environment will need to take special attention to maintain the person-centered and recovery-oriented intervention methods while working with clients who are also being mandated into treatment.

As a theoretical framework, SDT can be applied to FACT teams in order to establish how outcomes can be enhanced by means of examination of autonomous motivation, controlled motivation, causality orientation, and life goals (Deci & Ryan, 2008). Application of SDT to the FACT model of care will ensure that the best interests and outcomes of the client will still be

applied amid the mental health and justice-involved partnership. Person-centered and strength-based interventions utilized by social workers and other mental health professionals typically emphasize a collaborative working alliance with the person served in order to ensure that their needs are prioritized throughout the goal setting and helping process, which is a practice that does not involve the use of coercion. Social workers, who respect the autonomy and self-determination of the client, provide valuable evidence to counter the critique that ACT is an inherently coercive model. It will be the role of the social worker to ensure that the needs and self-determination of the client are being recognized, while also forming partnerships to support and educate criminal justice providers through an active collaborative partnership.

Conceptual Framework

The conceptual framework for this banded dissertation is self-determination theory (SDT). Edward Deci developed earlier work on this comprehensive theory of motivation with his research on intrinsic motivation in 1970. Richard Ryan began collaborating with him in the 1980s to develop the theoretical framework that represents the motives of competence, relatedness, and autonomy (Sheldon, Williams, & Joiner, 2003). These concepts form the basic categories of SDT that contribute toward a thriving or growth orientation that supports both relatedness as well as autonomy of the individual (Ryan & Deci, 2000). Self-determination theory embraces the assumption that all humans have an innate tendency to seek out an interconnectivity with self and others as well as toward an integration that includes aspects of both autonomy and homogeneity (Ryan & Deci, 2002).

The theory also provides a framework to assess the different types of motivation (autonomous and controlled), how people are motivated, psychological needs to be satisfied, and individual differences between needs for competence, relatedness, and autonomy (Deci & Ryan,

2008). The banded dissertation references potential application and analysis of how SDT has been, or could potentially be, integrated into the ACT/FACT service delivery model as a means to evaluate interventions involving use of coercive or overly paternalistic intervention strategies. The assumptions, philosophies, and service delivery model of the ACT/FACT model as measured by the Tool for Measurement of Assertive Community Treatment (TMACT) will provide the basis for which SDT will be applied. The questions explored include how the application of SDT's three basic motives of competence, autonomy, and relatedness will impact ACT/FACT service delivery in general as well as more specifically related to coercion and/or paternalistic interventions.

The TMACT is a newly refined fidelity measurement instrument that widened its scope around clinical and programmatic processes that were not covered under the previous measurement tool called Dartmouth's Assertive Community Treatment (DACT) scale (Moser, Monroe-De Vita, & Teague, 2013). The TMACT fidelity measurement instrument provides a framework to measure the effectiveness and adherence to the evidence-based practice of assertive community treatment (ACT). The new TMACT fidelity measurement scale introduced additional measures related to person-centered practices and planning that place a heavier emphasis on how staff work with clients from a recovery-oriented, strengths-based framework. The macro theory of self-determination theory (SDT) will serve as an additional tool from which to address distinctions between autonomous motivation and controlled motivation (Deci & Ryan, 2008) within ACT teams' adherent to TMACT fidelity standards.

There exists a new emerging model of care named forensic assertive community treatment (FACT) that works specifically with individuals in the criminal justice system, however, a FACT fidelity measurement tool is still under development (Lamberti, Weisman, &

Faden, 2004), so current FACT programs must rely upon the most recent TMACT fidelity tool until modifications are made based upon the populations differences of FACT clients compared to traditional ACT clients. This model may pose additional challenges regarding the use of coercion in practice interventions as social workers are in direct partnerships with the criminal justice service providers, and many clients will be mandated to treatment. The following evidence-based practices are woven into the TMACT tool to ensure adherence to the evidence-based practice of ACT: cognitive behavioral therapy (CBT), illness management and recovery (IMR), integrated dual disorder (IDDT), and motivational interviewing (Bond, 2002; Bond, Drake, Mueser, & Latimer, 2001). This researcher addresses the critique of the use of coercion through the lens of these evidence-based practices as well as application of SDT within the ACT service delivery model framework.

Summary of Banded Dissertation Products

This banded dissertation consists of one conceptual research manuscript, one quantitatively designed research manuscript, and an annotated analysis of the author's peer-reviewed presentation at a national conference. The first conceptual product is entitled "Application of Self-Determination Theory to Assertive Community Treatment Models of Care," which examines and demonstrates ways in which self-determination theory's (SDT) features of positive assumptions of autonomy, competence, and relatedness of human nature might be applied to the evidence-based practice of ACT and FACT. The paper provides a conceptual model of how the implementation of ACT/FACT could be accomplished in ways that prevent or minimize coercion by means of adopting principles of SDT. Self-determination theory supports practices that embrace both intrinsic and extrinsic motivation, and offers external, identified, introjected, and identified as three types of extrinsic motivation (Sheldon, Williams, & Joiner,

2003). Self-determination theory could help address criticisms regarding assertive community treatment (ACT) and forensic assertive community treatment (FACT) and help examine the model's utilization of paternalistic or coercive intervention practices with persons served. practices, and person-centered planning and practices (Moser, Monroe-De Vita, & Teague, 2013).

The second product entitled "Satisfaction of Basic Psychological Needs among Recipients of Assertive Community Treatment" is a quantitatively designed cross-sectional exploratory study that utilized data from 100 ACT clients using the client satisfaction questionnaire-8 and the self-determination theory scale of basic psychological needs. The study was designed to evaluate the relationship between client satisfaction and satisfaction of basic psychological needs associated with SDT. The study found a statistically significant relationship between client satisfaction and relatedness, which is one of the subscales within the basic psychological needs scale, and a relationship with autonomy and competence. Implications to inform best practice interventions for ACT and emerging models of care such as FACT were explored. The paper explored how SDT can support a client's self-determination and level of satisfaction thereby decreasing the use of coercive practice interventions among ACT and FACT teams This is a core value and principle associated with the profession such as NASW's Code of Ethics, which places client self-determination as a key ingredient to social work practice (NASW, 2008).

The third product entitled "Promoting Smart Decarceration Through Forensic Assertive Community Treatment" provides an annotated overview of a peer-reviewed presentation at the Council on Social Work Education's (CSWE) 63rd Annual Program Meeting (APM) entitled "Educating for the Social Work Grand Challenges.". The presentation included a brief overview

of the ACT and FACT models of care, an introduction and overview of SDT, an overview of research from the author's conceptual article on SDT and ACT, and a brief review of the research and findings from the author's data from the manuscript entitled "Satisfaction of Basic Psychological Needs among Recipients of Assertive Community Treatment." The overview of the interactive workshop included a breakdown of the various evidence-based practices utilized by ACT teams, FACT teams, and evidence-based core correctional practices. Examples of critiques of the ACT/FACT model were introduced and reviewed through the lens of SDT as well as through social work values and principles. Implications and applications for social work practice were reviewed and discussed with the emphasis on the role of the social worker among interdisciplinary teams.

Discussion

The research of this banded dissertation positions SDT as the theoretical framework to support how a person accesses ACT and FACT services through identification of different types of volitional engagement. A conceptual product regarding how SDT can be integrated in ACT and FACT community-based models of care and a quantitative research product testing the relationship between client satisfaction and satisfactions of the basic psychological needs of autonomy, competence, and relatedness are presented. Findings from these two products were then integrated into a presentation and introduced at a national peer-reviewed conference. The conceptual product presented a framework regarding how a person participating in a community treatment team may be anywhere along the motivational continuum ranging from amotivation, extrinsic motivation, or intrinsic motivation. SDT provides the mechanism and intervention methods to support a person's internalization, which is "[...] predictive of enhanced physical, psychological, and social wellness" (Vansteenkiste, Niemiec, & Soenens, 2010, p. 15). The

provider's goal is to help move the person move along the continuum from the status of non-self-determined to higher levels of self-determination, which is an intrinsic motivation when the person's interest and inherent satisfaction is fully realized (Deci & Ryan, 2000).

Research in this banded dissertation support SDT's tenets that a person can achieve satisfaction in treatment regardless of where they fall along this motivational continuum. This is an important distinction for clients who are involuntary due to a civil commitment or involvement with the criminal justice system. Both ACT and FACT teams can work with individuals regardless of their voluntary status and implement interventions which are not coercive in nature, but rather supportive of a person's basic psychological needs of autonomy, competence, and relatedness. Service providers who respect a person's autonomy by means of helping the client experience a sense of ownership and personal value to the treatment experience will be more successful in helping the person move from their status as an externally motivated (external regulation) to a place of full internalization (integrated regulation), which could lead to the development of intrinsic motivation.

This banded dissertation began with a review and analysis of how SDT can provide the theoretical framework to work with ACT and FACT clients utilizing autonomy-supportive interventions rather than coercion. Clients are still given a choice regarding admission to an ACT or FACT program, which is demonstrative of an external regulatory control wherein the person may experience pressure to make a decision due to influence from the courts or criminal justice system; however, it is important to communicate the message of choice. The quantitative research findings in this paper revealed a relationship between client satisfaction and SDT's satisfaction of basic psychological needs of autonomy, competence, and relatedness. This is applicable for ACT and FACT clients regardless of their type of volitional engagement. This

research supports the importance for ACT and FACT teams to utilize voluntary and collaborative treatment approaches which respect client choice and self-determination, and the need to abstain from the use of coercion in the delivery of services. This may be an area of confusion as a client may be involuntary, yet they still have a choice regarding the type of treatment and services they access outside of involuntary incarceration.

Self-Determination theory is closely aligned with the professional standard of ethics and values in the social work profession. The National Association of Social Workers (NASW) Code of Ethics (2008) identified the following values and ethical principles which are just a couple of the principles supported by SDT: dignity and worth of the person and self-determination. These are but a few of the values and ethical principles in which the empirical support from SDT has provided a framework to help promote and respect a client's dignity and self-determination. SDT empirical research has demonstrated how people will exhibit greater psychological health and well-being when their capacity to strive toward intrinsic autonomy is most supported. A person's self-determination is supported as a person internalizes and integrates external regulations, or works toward strengthening intrinsic motivation, which helps them exhibit higher levels of engagement, "[...] vitality, and creativity in their life activities, relationships, and life projects" (Deci & Ryan, 2012, p. 85). This theory provides a framework to support and better understand how a practitioner can best support and promote a client's self-determination as stated in the Code of Ethics as it embraces the idea that all humans have the drive toward autonomous states and takes notice of how it can help inform how to support a person in either fully autonomous or full controlled states (Deci & Ryan, 2012).

Implications for Social Work Practice and Education

The extensive evidence and empirical support of SDT reveals that it can be applied with confidence across diverse practice settings ranging from psychotherapy, parenting, healthcare, education, relationships, sports, physical activity, and environmental science (Vallerand, Pelletier, & Koestner, 2008). It is also important to note that the key concepts of competence, autonomy, and relatedness within the SDT framework is represented on the continuum of motivational and regulatory styles (autonomy continuum) that has been applied and replicated across vastly different types of individuals, groups, cultures, and ages in empirical research designs (Ryan & Deci, 2006). SDT has been validated empirically, therefore, it can provide a model for clinicians and educators to apply the motivational theory which is likely to not only enhance the efficacy of empirically validated treatment programs, but also “[...] suggest ways of limiting the influence of pernicious therapists and programs” (Sheldon, Williams, & Joiner, 2003, p. 112).

Extensive empirically-supported research has supported SDT’s position that human motivation is driven by psychological needs of competence, autonomy, and relatedness (Deci & Ryan, 2000). These empirical research findings of SDT illustrate the importance to bolster SDT’s basic psychological needs of autonomy, competence, and relatedness in every helping context in order to achieve positive outcomes. SDT’s findings revealed that “[...]when satisfied yield enhanced self-motivation and mental health and when thwarted lead to a diminished motivation and well-being” (Ryan & Deci, 2000, p. 68). The idea that when a person’s basic psychological needs are thwarted as opposed to satisfied provides robust empirical support to inform how a person in the helping profession implements an intervention whether it be a mental health professional or educator.

Implications for Future Research

The Council of Social Work Education's (CSWE) Educational Policy and Accreditation Standards (EPAS) emphasize the importance for social workers to demonstrate a holistic competence, which is comprised of the use of knowledge, values, skills, and cognitive and affective processes in practice settings (2015). Another conceptualization of holism can be understood through a bio-psycho-social framework, which takes into consideration "[...] the physical, cognitive, emotional, behavioral, and spiritual dimensions of the person as these are connected to environmental contexts" (Forte, 2014, p. 265). Self-determination theory embraces the holistic standards identified above by means of its embrace of the organismic approach, which assumes that humans act on their internal and external environments, and that behavior is influenced by both the self and environment as humans thrive toward development of a unified self (Deci & Ryan, 1985).

This theory of human motivation can provide a lens to help inform practice interventions across disciplines. Areas to explore for future research include creation and testing of validated instruments to measure the satisfaction of basic psychological needs in different settings for a variety of populations. The sample population of vulnerable adults with a serious and persistent mental illness in this study serve as one example. One survey or instrument to measure outcomes may not be effective across groups. Additional areas for future research may also include evaluation and assessment regarding how to disseminate SDT into various practice settings. Specifically researching best practices regarding how to teach providers the deeper meaning of autonomy, competence, and relatedness will inform how to best operationalize these tenets in practice. The empirical literature on SDT supports a theoretical framework to inform practice interventions that ensure that the self-determination of the person is supported and understood to

be a fundamental component to facilitate a person's satisfaction of basic psychological needs, which is a fundamental value of the social work profession. The robust empirical support for how SDT can help support the autonomy of both autonomous and non-voluntary clients is aligned with social work ethics and values.

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Application of Self-Determination Theory to Assertive Community Treatment Models of Care

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Abstract

The theory of self-determination theory (SDT) will serve as a useful conceptual framework to examine aspects of assertive community treatment and forensic community treatment community-based models of care. Findings from STD research have revealed that clients achieve greater outcomes, longevity, and satisfaction in autonomy-supportive therapeutic environments; therefore, may provide a model for assertive community treatment teams to enhance quality of care, increase client satisfaction, increase client collaboration, and lower resistance to care. SDT will provide a model to decrease the frequency of coercive interventions and increase voluntary client involvement in their care. Assertive community treatment and forensic assertive community treatment service delivery models are designed to serve individuals diagnosed with a serious and persistent mental illness (SPMI). Assertive engagement approaches such as court commitments, intensive medication monitoring, and use of contingency management strategies are often utilized to promote client adherence to treatment. This has led to criticism of the model as overly paternalistic or coercive, which will be addressed through application of SDT.

Keywords: assertive community treatment, forensic assertive community treatment, self-determination theory, coercion, autonomy

Application of Self-Determination Theory to Assertive Community Treatment Models of Care

Assertive community treatment (ACT) is an evidence-based service delivery model designed to serve individuals with a serious and persistent mental illness (SPMI) in their preferred living environment. This model of care was designed to provide integrated multidisciplinary care for individuals with high needs who require more intensive support to remain successful in the community. Examples of high needs include individuals who struggle to manage their mental illness and frequently access inpatient psychiatric hospitals. Services provided by an ACT team help individuals decrease the number of visits to inpatient psychiatric hospital facilities and enhance a person's quality and stability while living in the community (Stein & Santos, 1998). The ACT model is designed to work with individuals who have not responded positively to traditional office-based models of mental health care and utilizes assertive engagement approaches to serve both voluntary as well as involuntary clients. The client may experience assertive engagement approaches as coercive if they are not implemented within a strength-based, recovery-oriented framework. The self-determination theory (SDT) can provide an empirical foundation to facilitate practitioner use of interventions that support a client's thriving toward optimal healthy behavioral and psychological functioning, which embraces a client's autonomy (Ryan & Deci, 2017). Application of SDT to ACT and forensic assertive community treatment (FACT) models of care will ensure that clients' autonomy and self-determination are respected amid the application of coercive interventions such as civil commitments and use of legal leverage.

An emerging model of care named FACT utilizes the same multidisciplinary framework as ACT. However, it is designed to work solely with justice-involved clients referred from jail or prison. FACT teams maintain close partnerships with the criminal justice community and partner

directly with the client's supervising agent, commonly referred to as a probation or parole officer. Critics state that the assertive engagement strategies of these models of care are overly paternalistic or coercive. The FACT model may pose additional challenges regarding the use of coercion in practice interventions. Social workers engage in active collaborative partnerships with the criminal justice service providers and the courts to receive treatment will mandate many clients. SDT established that intrinsically motivated prosocial behavior is best supported when a person's basic psychological needs are satisfied, whereas the opposite is true when a person's basic psychological needs are thwarted (Ryan & Deci, 2017). This theory will provide a useful framework to foster a client's motivation to engage in treatment with ACT and FACT providers.

Theoretical Framework

SDT embraces the assumption that all humans have an innate tendency to seek out interconnectivity with their self, with others, as well as toward an integration that includes aspects of both autonomy and homogeneity (Ryan & Deci, 2002). The theory also provides a framework to assess the different types of motivation (autonomous and controlled), how people are motivated, psychological needs to be satisfied, and individual differences between needs for competence, relatedness, and autonomy (Deci & Ryan, 2008). The key concepts of competence, autonomy, and relatedness within the SDT framework is represented on the autonomy continuum of motivational and regulatory styles with replication across vastly different types of individuals, groups, cultures, and ages in empirical research designs (Ryan & Deci, 2006).

SDT could help address criticisms regarding ACT and FACT and help examine the model's utilization of paternalistic or coercive intervention practices with persons served. This paper will examine and demonstrate ways in which SDT's features of positive assumptions of autonomy, competence, and relatedness of human nature might be applied to the evidence-based

practice of ACT/FACT and how adaptation of SDT principles could help prevent or minimize coercion. Social workers have an ethical obligation to respect the self-determination and autonomy of the vulnerable adults served by this model of care, as coercive approaches could also lead to harm and are often contradictory to a recovery model of care.

Purpose Statement

Deci and Ryan (2000) have produced extensive empirical research, demonstrating how an integration of autonomous motivation yields “[...] greater psychological health and more effective performance on heuristic types of activities” (p. 183), as well as long-term persistence and maintenance of healthy behaviors. Their research has revealed that when a client’s basic psychological needs of competence, relatedness, and autonomy are satisfied, their self-motivation and mental health improve. Clients exhibit diminished motivation and well-being when these basic psychological needs are thwarted. Examined in this paper is the SDT as the theoretical framework for the ACT model of care to provide approaches supportive of client autonomy. SDT will provide useful framework to help ACT and FACT staff respect a person’s autonomy and self-determination. In this context, the individual experiences a sense of ownership and personal value to the treatment experience with the hopes that they will eventually move from their status as an externally motivated (external regulation) person to autonomous motivation.

Literature Review

Early Development of Assertive Community Treatment

The assertive community treatment (ACT) model of care was developed in 1970 by a group of staff at the Mendota Health Institute in Madison, Wisconsin, who recognized the need to treat people with complex needs in the community rather than during long-term inpatient

hospital stays (Allness & Knoedler, 2003). Stein and Test's (1980) research revealed high levels of hospital recidivism among individuals with complex functional impairments such as SPMI diagnoses, substance use disorders, and comorbid medical conditions. They realized that more intensive community-based interventions were needed to help individuals manage complex needs in their own living environments. The original ACT model developed during this early period was strongly influenced by the medical model and was often referenced to as a community based "hospital without walls" (Stein & Test, 1980).

The community-based model of care was considered less restrictive than hospital settings. The model remained clinician driven, as staff worked to help individuals remain in the community, reduce hospital recidivism, and access needed supports such as mental health and housing services. ACT teams were primarily invested in providing in-vivo, time-unlimited services to both voluntary and involuntary clients with a focus on reducing hospital recidivism and providing essential comprehensive community care (Dennis & Monahan, 1996). Fidelity instruments such as the Dartmouth ACT Fidelity Scale (DACTS) measures the degree to which interventions remained consistent across practice settings. The DACTS does not measure the degree in which ACT utilizes coercive or aggressive intervention approaches to achieve positive outcomes, which was measured as decreased hospital recidivism at that time. An instrument to govern the types of interventions utilized by ACT teams could serve to curtail the use of unnecessary coercive interventions in addition to analysis of rates of hospital recidivism. Many of the interventions used in ACT and FACT models contain assertive engagement approaches. It will be important to conceptualize when it is necessary to use these types of approaches rather than motivationally-inspired approaches that respect a person's autonomy and self-determination.

Assertive Community Treatment as Coercion

Gomory (2015) is among one of many scholars to suggest that ACT treatment approaches over-utilize paternalistic or coercive interventions to promote client adherence to treatment. Several researchers reference examples of various intervention strategies they deem coercive and unethical, such as use of incentives for medication and treatment compliance, frequency of client visits to elicit engagement, mandated treatment through mental health court systems (commitments), use of leverage with housing and payee services, or partnerships with the criminal justice system (Diamond, 1996; Fisher & Ahern, 2000; Gomory, 1999, 2001; Kirk, Gomory, & Cohen, 2013; Spindel & Nugent, 2000; Szmukler, 1999). One study revealed partnerships with probation, parole agents, and mental health workers resulted in an increased use of coercive interventions and rates of incarceration (Draine & Solomon, 2001).

Both the ACT and FACT models are guided by a fidelity instrument designed to promote self-determination and independence (Moser, Monroe-Devita, & Teague, 2013). The use of more assertive engagement treatment approaches is to be implemented secondary to strength-based and recovery approaches associated with a client's self-determination according to ACT fidelity. Specifically, looking at the empirical research and evidence of the use of coercion in social work practice among ACT teams will also serve to inform best practice interventions for emerging models of care such as FACT. The FACT model utilizes ACT as the framework and philosophical foundation for practice. The presence of misguided or overuse of coercive practice interventions among ACT teams is a concern for social workers who uphold core values and principles associated with the profession such as National Association of Social Worker's (NASW) Code of Ethics, which places client self-determination as a key ingredient to

social work practice (2008). SDT will play a critical role in helping practitioners support a client's self-determination.

Diamond (1996) is one of the earliest critics of the ACT service delivery model has utilized the label "aggressive community treatment" (p. 55), to characterize the nature of paternalistic interventions to control behavior through control of resources. Suggested coercion only provides a short-term solution to long-term problems. He referenced the important continuum of coercive interventions that range from friendly persuasion, interpersonal pressure, control of resources, use of force, and court commitment being on the most extreme end of the coercion continuum (Diamond, 1996). It is important to clarify that Diamond did not view coercion as inherently malevolent per se yet cautioned against overuse of paternalist overly coercive interventions that can produce negative treatment outcomes, which may thwart an individual's autonomy and self-determination.

Coercive interventions deemed less intrusive or perceived positively by the client could include various contingency management strategies. Examples include offering a Subway gift card to a person who comes to the office to receive their injectable medication, taking the client to lunch for engagement and relationship building, or offering to pay rent to avoid eviction. These types of interventions may have coercive elements yet are not perceived in that manner if the person's autonomy and self-determination are respected by the staff member. ACT teams work with people with complex needs, which require creative interventions to engage people who often have little insight into their illness and recovery and are often disengaged from treatment (Angell, Matthews, Barrenger, Watson, & Draine, 2014).

Aggressive Community Treatment

The ACT service delivery model serves individuals who have not responded positively to traditional mental health treatment services for reasons such as negative experiences with providers. This has often led to distrust of the system and lack of interest in receiving any type of mental health services. Clients are also mandated into ACT treatment through an outpatient commitment order, which is coercion through use of legal leverage (Pirdham et al., 2016). The ACT teams utilize various assertive engagement and retention strategies to establish therapeutic rapport and do not simply give up if the client declines to see the team member. This type of practice has resulted in the labeling of ACT as aggressive community treatment (Dennis & Monahan, 1996).

Repeated attempts and strategies will be utilized to develop a therapeutic alliance regardless of the client's declination of services. These types of assertive engagement practices have been critiqued as anti-recovery as they are perceived as coercive or paternalistic (Anthony, Rogers, & Fargas, 2003; Gomory, 2001). The team-based approach to serving individuals who are presented with higher-level, complex needs and challenges requires more aggressive efforts by a multidisciplinary team. This is another reason why the ACT may, at times, be experienced as overly coercive or controlling (Angell & Bolden, 2016). These type of assertive engagement approaches utilized by a multidisciplinary team must be implemented with care to maintain the therapeutic alliance and prevent clients' perception of being coerced. The application of SDT within a strength-based, recovery oriented framework can be most useful to guide client care and help prevent overutilization of coercive interventions.

Other scholars vituperative of the ACT model of care have expressed disapproval of both ACT and community psychiatry. Kirk, Gomory, and Cohen (2015) referenced their belief that

the only reason ACT is successful in decreasing hospital recidivism is due to coercive administrative control over hospital admissions. The authors suggested that ACT has not been effective in symptom reduction as reduced hospital stays does not suggest decreased expression of symptoms per se. Kirk, Gomory, and Cohen (2015) referenced additional interventions utilized by ACT teams they believed to be coercive such as “blackmailing patients” (p. 106), to promote medication adherence and “threatening to withhold monies” (p.106), as leverage to engage in treatment.

Additional coercive strategies include the use of a payee to withhold money if a client does not take their medications or use of bribery to promote adherence to treatment (Kirk, Gomory, & Cohen, 2015). Gomory (1999) also dismissed the randomized control treatment studies that support the efficacy of ACT by suggesting that “once research careers are established around specific treatment paradigms they need for self-justification rarely allows admissions of error” (p.14). The author expounded upon his belief that ACT is a potentially abusive program that continues to expand and be funded due to adherence and promulgation of the medical model of care, which labels mental illness as a brain disease. There exists alternative research and viewpoints that reference the need for ACT teams to rely less upon the medical model, while also noting that ACT teams can also operate from a recovery-oriented framework. ACT can be perceived as coercive if not implemented according to the model’s fidelity or if staff is not properly trained. The application of SDT along with training in recovery-oriented interventions can ensure that ACT staff utilize supportive motivational enhancement strategies as the first line approach to treatment.

Angell and Bolden’s (2015) research utilized conversational analysis methodology to explore interventions used by the ACT team psychiatrist engaged in medication prescribing

practices with clients. The authors found that psychiatrists tended to utilize more authority-based practices in medication management practices rather than methods that increase client participation. It will be important to expand upon this research to explore strategies that support how psychiatrists work in collaboration with ACT team members and how they balance their use of medical authority with client empowerment strategies. It is important to recognize how the teamwork approach of ACT can provide greater opportunity for collaboration and for the client to feel represented by a unified team of providers. However, research has also suggested that benefits of collaboration may also be experienced by clients as an amplification of social control and increased perceptions of coercion (Angell & Bolden, 2015; Angell & Bolden, 2016).

This is demonstrative of ACT teams utilizing coercive practices that contradict best practices articulated in ACT fidelity. The application of SDT could provide an additional theoretical framework to support a client's autonomy, competency, and relatedness. An additional study by Angell, Mahoney, and Martinez (2006) found that the most frequently utilized approaches among ACT teams in their study included coercion. Examples include leverages, threats, or force for clients mandated into treatment. This research aligns with the Draine and Solomon (2001) study that demonstrated a higher use of "[...] threats and sanctions to compel adherence to treatment" (Angell, Mahoney, & Martinez, 2006, p. 516). There is a wide variability in how ACT teams operate and much of its variance is due to the culture of the team and how they work together to support a recovery-oriented treatment environment. It will be useful to examine the different types of variability and common characteristics associated with teams using coercion and recovery-oriented practices. A comparison will lead to analysis of examples, which coercion is utilized and to ascertain circumstances in which SDT can most

applicable.

Variability of Coercion used Across Teams

There also exists research that reveals a higher use of recovery-oriented practices as opposed to coercive interventions among ACT teams. Kidd et al. (2010) revealed the use of moderate-high ratings of recovery-oriented service interventions among 67 ACT teams, which is the largest sample of ACT teams covered in one study. The study did not reveal a relationship between high fidelity and recovery-oriented interventions. Moser and Bond (2009) also revealed no relationship between high fidelity and agency control. They also found a large degree of variability regarding the use of agency control (coercion) among the 23 ACT teams they researched.

The researchers revealed through their findings that ACT services were not inherently coercive. There here are many instances in which use of agency control is appropriate per the individual needs and preferences of the person served. Similar findings were revealed by Manuel, et al. (2013), who found considerable variation in use of coercive interventions among 34 ACT teams. They discovered the two most significant characteristics that led to use of coercive interventions, including a demoralized organization climate and stigmatizing beliefs about mental illness. This suggests that ACT teams exposed to additional trainings and team building activities may increase their use of recovery-oriented strategies. Training activities that included use of SDT would strongly enhance staff relationships with persons served as well as help reduce burnout, as it helps decrease client resistance to care.

The research regarding critiques of ACT as an inherently coercive model of care is quite variable. It follows that the scope and practice of coercive interventions is dependent upon the differences between ACT team characteristics and client needs. The research revealed the

differing types of coercive interventions and how coercion may, at times, be useful in treatment. It is important to note that it must be conducted with respect and dignity of the person and toward reinstating the client's autonomy and competency as quickly as possible following the coercive event. Further review of the ACT empirical research does suggest that ACT team members, including psychiatrists, may need to pay closer attention to use of collaboration and avoid more authoritarian or coercively-informed practices. SDT provides a useful framework to ensure staff are utilizing more recovery-oriented practices, while also following fidelity standards. The following section will analyze the ACT and FACT fidelity standards to determine the degree that recovery-oriented interventions are implemented and where the application of SDT could enhance a team's commitment to increased collaboration in treatment.

ACT and FACT Fidelity

The Dartmouth Assertive Community Treatment Scale. This is a fidelity instrument that was developed to define explicit ACT model criteria to guide effective interventions and consistent program outcomes (Teague, Bond, & Drake, 1998). This fidelity measurement tool primarily focuses on the structural elements of the ACT model. It lacks coverage regarding structural components of the model, such as use of person-centered planning and practices as well as use of empirically supported evidence-based practices (Teage, Mueser, & Rapp, 2012). A newer fidelity instrument was created to address these missing components as well as offer additional guidelines and empirically supported interventions to guide treatment.

The tool for measurement of assertive community treatment. This is a fidelity measurement tool created to address the DACT's lack of coverage for these critical ingredients. The TMACT fidelity measurement instrument provides a framework to measure the effectiveness and adherence to the evidence-based practice of ACT. The TMACT is a more

rigorous fidelity measurement scale that introduced additional measures related to person-centered practices and planning that place a heavier emphasis on how staff work with clients from a recovery-oriented, strengths-based framework (Moser, Monroe-De Vita, & Teague, 2013). Regardless of the adaptation of improved, more rigorous ACT fidelity scales, concerns related to overuse of overly paternalist and coercive interventions continue to persist (Angell & Bolden, 2015; Angell, Mahoney, & Martinez, 2006). Integration of a more specialized training in SDT could help address the prevalence of coercive strategies across ACT programs.

Levels of perceived coercion. It is important to gain a clear understanding of the circumstances under which ACT team members might engage in coercive or paternalistic interventions. It will also be important to assess which interventions are perceived to be controlling by both staff and clients. There are instances where paternalist or coercive interventions are used by ACT team members to encourage treatment adherence and navigate barriers to accessing needed care. Examples include use of community treatment orders and contingency management strategies. Sturn, Rugkasa, Landheim, and Wynn's research (2015) revealed a variation in whether clients experience these types of coercive interventions as a violation of their autonomy. An intervention may be inherently coercive, yet not experienced as coercive by the client. The newer TMACT instrument directs staff to respect a client's self-determination and independence to help clients develop greater awareness in order to make meaningful choices and decisions about their treatment (Monroe-DeVita, Moser, & Teague, 2013). The TMACT is the fidelity instrument used to gauge adherence to the evidence-based practice of ACT.

Assertive engagement approaches. The use of assertive engagement mechanisms as well as respect for the client's self-determination is embedded within this instrument. TMACT

provides the framework to guide ACT teams' utilization of motivational enhancement strategies prior to resorting to more coercive or paternalistic interventions, yet studies reveal that staff continue to engage in these types of practices (Angell & Bolden, 2015; Angell, Mahoney, & Martinez, 2006). Emerging models of care such as FACT programs rely upon the TMACT to measure adherence as well; however, there are additional challenges posed to a client's autonomy and self-determination. This reveals that TMACT fidelity alone does not have a substantial and consistent impact to guide a recovery-oriented standard of care. An integration of SDT into the FACT model of care will help address the additional challenges.

Forensic assertive community treatment. The FACT model, by design, utilizes more coercive interventions such as partnership with the justice community and mandates for treatment. It is important to evaluate how client self-determination and autonomy are maintained, as these types of newer models of care develop, and how adherence to TMACT fidelity might impact the frequency of coercive practices. A combination of SDT and adherence to fidelity will assist with staff accountability in the provision of collaborative client care in autonomy thwarting environments. The newer emerging model of care named FACT works specifically with individuals in the criminal justice system. However, a FACT fidelity measurement tool has not yet been validated (Lamberti, Weisman, & Faden, 2004). Current FACT programs must rely upon the most recent TMACT fidelity tool until modifications are made based upon the population's differences of FACT clients compared to traditional ACT clients. The use of the TMACT protocol to assess and guide treatment protocol poses challenges for the FACT model as it utilizes an increased use of coercive practice interventions by means of the direct partnerships with the criminal justice service providers. This includes use of therapeutic jurisprudence and client mandates to receive treatment via criminal justice providers. These

types of extrinsic motivators can include various applications of what may seem to be coercive or paternalist, such as using rewards or engaging in treatment to avoid re-incarceration (punishment). However, SDT suggests that the extrinsic motivators can eventually be internalized and be experienced as authentic as clients begin to take greater ownership of their treatment experiences (Ryan & Deci, 2008).

Variations between models of care. The significant differences of the FACT model should be examined to determine whether modifications might need to be made for an alternative FACT fidelity instrument, which utilizes concepts borrowed from SDT. An evaluation of past and current critiques regarding the use of coercive or paternalistic practice interventions in the ACT and FACT models will help inform how SDT can be integrated into a FACT fidelity instrument. SDT is a macro theory that will serve as an additional model to address distinctions between autonomous motivation and controlled motivation among ACT teams' adherent to TMACT fidelity standards (Deci & Ryan, 2011).

Discussion

Fidelity and Agency Control

The TMACT instrument to measure fidelity on ACT and FACT teams provides a framework to promote recovery-based interventions; however, there remains no clear measure for a person's recovery-orientation. It is difficult to ascertain the degree in which high TMACT fidelity scores are correlated with implementation of recovery-oriented FACT interventions. Moser and Bond's (2009) research revealed no relationship between fidelity and use of agency control, which suggests that higher scoring fidelity teams are not necessarily better at utilizing person-centered, recovery-oriented practices as opposed to more coercive interventions.

The researchers noted a positive relationship between higher education levels of staff and decreased use of coercive interventions, which suggest that less educated staff are more likely to utilize paternalistic interventions (Moser & Bond, 2009). Introducing SDT in these contexts could provide staff with the additional education needed to support a client's basic psychological needs, which promotes recovery-oriented practices supportive of a person's strength and resiliency (Ryan & Deci, 2017). Social work educators will play a vital role in ensuring that recovery-oriented, strength-based, and person-centered practices are represented in the curriculum and classroom. Students graduating from social work programs will then be better equipped to provide interventions that are supportive of a client's autonomy and model best practices for other disciplines in the field of behavioral health.

Fidelity and Recovery Orientation

There exists a good reason for ACT and FACT teams to strive toward achieving high TMACT fidelity, despite its limitations. Substantial empirical research has revealed that teams with higher fidelity generally achieve better client outcomes (Teague, Mueser, & Rapp, 2012). Examples include higher TMACT scores that are correlated to reduced number of hospital and acute crisis unit stays; however, the authors found no relationship between higher scores and the probability of hospital admissions or arrest rates (Cuddeback et al., 2013). This is indicative of higher scoring teams not necessarily being more effective at achieving positive client outcomes associated with recovery or criminal recidivism. Frequency of access to hospital and acute crisis facilities is associated with clients experiencing high levels of psychiatric or psychosocial problems, requiring more intense and restrictive support. Hospital settings typically utilize more authority-based coercive interventions, which may certainly meet the person's immediate

psychological needs. SDT postulates that this type of coercion or pressure will diminish long-term well-being as well as engagement and motivation (Deci, Ryan, Schultz, & Niemiec, 2015).

Implications for Practice

Many clients served by ACT and FACT teams are not motivated to engage in treatment. Mulder, Jochems, and Kortrijk's (2014) research with clients in an inpatient setting revealed that persons with an SPMI disorder with high levels of psychosocial problems were less motivated to engage in treatment and reported lower quality of life. It is, therefore, essential to not only establish a collaborative therapeutic alliance but also utilize evidence-based practices and motivational enhancement strategies that have proven most effective at serving persons with complex needs (Bond & Drake, 2015). SDT is a theory of motivation that addresses the type of motivation exhibited by clients on ACT and FACT teams as well those in inpatient psychiatric settings. One of the greatest challenges for ACT and FACT teams is the process of engagement and creation of a therapeutic alliance with people who experience severe and persistent mental health symptoms and are not interested or motivated to participate. Clients who are mandated into treatment or coerced via legal leverage are not given autonomy to receive community or inpatient treatment. It is therefore important that service providers are equipped with a strong recovery-focused paradigm and principles of SDT to ensure the use of supportive adherent strategies that enhance capacity for satisfaction of their basic psychological needs.

Integration of SDT's basic psychological needs of competence, relatedness, and autonomy on ACT and future FACT fidelity scales would provide a solid foundation to measure the level of support for clients in autonomy thwarting environments. Addressing these three areas of a person's basic psychological needs could support person's movement along SDT's continuum

from controlled to autonomous motivation and help the person achieve autonomous self-regulation (Ryan & Deci, 2017).

Future Research

Future research should examine the relationship between high fidelity TMACT scores and frequency of coercive practices. Application of SDT within the TMACT and FACT fidelity model will provide a useful training framework for ACT and FACT teams and help decrease the frequency of coercive interventions. Social workers in this practice environment will need to take special attention to maintain the person-centered and recovery-oriented intervention methods while working with clients who are also being mandated into treatment. SDT will provide the framework for practitioners to maintain a strong therapeutic alliance thereby decreasing instances of perceived coercion in social work practice settings.

Satisfaction of Basic Psychological Needs Among Recipients of Assertive Community
Treatment

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Abstract

Assertive community treatment (ACT) has been critiqued as being overly coercive. It is also true that many ACT teams provide services with a stronger recovery orientation, which respects the self-determination of the person served. This paper evaluates the relationship between client satisfaction and the tenets of the self-determination theory's basic psychological needs of autonomy, competence, and relatedness. This cross-sectional exploratory study utilized data from 100 ACT clients using the Client Satisfaction Questionnaire-8 and the self-determination theory scale of Basic Psychological Needs. The multiple linear regression analysis revealed the model was significant, indicating that autonomy, competence, and relatedness accounted for approximately 22% of the variability in satisfaction. The Beta coefficients (β) represent standardized values of the predictive strength of each independent variable, which can be compared directly to one another. Client satisfaction scores were found to be above average. Further research with a larger sample size is needed to determine the relationship between client satisfaction and the subscales of autonomy and competence. Integration of the self-determination theory into the ACT model of care will provide an empirical platform to bolster positive client outcomes such as client wellness and engagement with treatment.

Keywords: assertive community treatment, self-determination theory, client satisfaction

Satisfaction of Basic Psychological Needs among Recipients of Assertive Community Treatment

Assertive community treatment (ACT) is a community-based model of care designed to provide in vivo assessment, training, and support to individuals diagnosed with a serious and persistent mental illness (SPMI) by utilizing assertive engagement and outreach approaches (Bond & Drake, 2015). This evidence-based service delivery model has proven to be effective at preparing clients to remain successful in community-based living environments (Stein & Test, 1980). ACT was designed to serve individuals with high needs who have not responded positively to traditional models of care and who require a higher level of multi-disciplinary care to thrive in a community-based living environment (Allness & Knoedler, 2003).

ACT national standards and ACT fidelity standards state that interventions should support client self-determination, which includes support for autonomy and choice as much as possible, as well as competency in daily living activities and other life areas, and relatedness with friends and supports in the community (Allness & Knoedler, 2003; Bond, Drake, Mueser, & Latimer, 2001; Monroe-De Vita, Moser, & Teague 2013; Moser, Monroe-De Vita, & Teague, 2013). The purpose of this study is to assess the extent to which clients on ACT teams believe their basic psychological needs of autonomy, competency, and relatedness are being supported. The study will also assess clients' level of satisfaction with their ACT services and the relationship between the level of satisfaction with ACT services and satisfaction of basic psychological needs.

Unfortunately, studies have shown that many clients served by ACT teams are not motivated to engage in treatment (Angell & Bolden, 2015; Corrigan et al., 2012; Salyers & Tsemberis, 2007; Stanhope, Marcus, & Solomon, 2009; Szmukler & Appelaum, 2008).

Numerous studies have evaluated different ACT strategies to address treatment non-adherence or

disengagement (Angell, Mahoney, & Martinez, 2006; Angell, Matthews, Barranger, Watson, & Draine, 2014; Appelbaum & Le Melle, 2008; Stuen, Rugkasa, Landheim, & Wynn, 2015; Watts & Priebe, 2002). However, the author is not aware of any previous studies that have explored how to increase intrinsic motivation and treatment adherence using the self-determination theory's (SDT) basic psychological needs of autonomy, competence, and relatedness (Deci & Ryan, 2000). SDT is a theory of human motivation that can be applied to ACT settings to better address the type of amotivation exhibited by clients as well as the overly coercive interventions often utilized by ACT staff (Angell, Martinez, Mahoney, & Corrigan, 2007; Crilly, 2008; Monahan, et al., 2001; Monahan, et al., 2005; Moser & Bond, 2009; Sheehan & Burns, 2011).

SDT's tenets of basic psychological needs provides the framework for how motivation to change occurs in autonomy-supportive environments and offers the framework to optimize use of evidence-based practices (EBP) such as ACT (Ryan, Lynch, Vanteenkiste & Deci, 2011). According to Ryan and Deci (2017), promotion of autonomy support, competence, and relatedness in the therapeutic relationship will lead to increased maintenance of change and improved psychological well-being of the client. Interventions guided by SDT will assure that ACT interventions embrace autonomy-supportive methods in autonomy-supportive environments (Ryan & Deci, 2008). Addressing these three areas of a person's basic psychological needs could support movement along SDT's continuum from controlled to autonomous motivation and help the person achieve autonomous self-regulation (Ryan & Deci, 2017).

Hence, this study is interested in assessing the extent at which the integration of SDT's basic psychological needs of autonomy, competence, and relatedness into the ACT model would increase client motivation to engage in treatment, increase client satisfaction of services, and

minimize use of coercive interventions among ACT staff. This study uses a cross-sectional exploratory quantitative design to assess the relationship between satisfaction of a person's basic psychological needs and level of satisfaction with ACT services. Deci and Ryan's (2000) Basic Psychological Need Satisfaction Scale (BPNS) and Attkisson's (1982) Client Satisfaction Scale (CSQ-8) are two survey instruments used to assess satisfaction of basic psychological needs and client satisfaction. Approximately 150 clients from six ACT teams in three counties in the midwest were administered the two surveys. It is hypothesized that ACT clients who believe their self-determination is being supported will report higher levels of satisfaction with ACT services.

Literature Review

Assertive Community Treatment and Recovery Orientation

Services provided by ACT teams help individuals decrease the number of visits to inpatient psychiatric hospital facilities and enhance their quality of life and stability while living in the community (Bond, Drake, Mueser, & Latimer, 2001; Bond et al., 1991; Cuddeback et al., 2013; Domino, Morrissey, & Cuddeback, 2013; Manuel et al., 2013; Salyers & Tsemberis, 2007; Stein & Santos, 1998). Along with decreased hospitalizations, ACT is also associated with positive outcomes related to increased housing stability and longer retention in treatment (Monroe-Devita, Morse, & Bond 2012). The ACT model is designed to provide multi-disciplinary services to individuals with serious and persistent mental illnesses, who are often quite difficult to engage, have severe psychiatric and psychosocial impairment, and have not responded positively to traditional office-based models of mental health care (Finnerty et al., 2015). ACT utilizes assertive engagement approaches to serve both voluntary as well as involuntary clients (Allness & Knoedler, 2003; Manuel et al., 2013; Monahan et al., 2005; Moser

& Bond, 2009; Moser, Monroe-DeVita, & Teague, 2013; Stein & Santos, 1998). Involuntary clients include individuals who are on commitment or community treatment order (CTO). Some studies have found that individuals on CTO's experience various levels of coercion during their treatment experience (Kisely & Campbell, 2015; Pridham, 2016). ACT services for both voluntary and involuntary clients may be experienced as coercive if the intervention is not implemented within a strength-based, recovery-oriented framework (Angell, Martinez, Mahoney, & Corrigan, 2007; Drake & Deegan, 2008). The constructs associated with a recovery-orientation such as person-centeredness and a non-judgmental attitude are congruent with self-determination constructs of autonomy, competence, and relatedness. These tenets have been associated with positive outcomes and increased motivation to engage in changed behavior (Deci & Ryan, 2012; Ryan & Deci, 2008).

Studies demonstrate that higher use of coercive practices negatively impacts clients' relationships with the provider as well as perceptions regarding quality of care (Sheehan & Burns, 2011; Strauss et al., 2013). On the other hand, studies also show that clients who believed their autonomy was respected and who experienced genuine collaboration with staff reported higher levels of improvement, regardless of levels of perceived coercive practices among clients (Angell, Matthews, Barranger, Watson, & Draine, 2014; Stanhope, Marcus, & Solomon, 2009). The ACT model is designed to promote self-determination and independence (Moser, Monroe-DeVita, & Teague, 2013). The National Program Standards for ACT teams and ACT fidelity measurement guidelines suggest the use of strength-based recovery-oriented approaches, such as motivational enhancement strategies, before implementing more assertive engagement treatment approaches (Allness & Knoedler, 2003; Moser, Monroe-Devita, & Teague, 2013). The use of

recovery-oriented approaches such as motivational interviewing is more closely aligned with the tenets of SDT, which support a person's autonomy, competence, and relatedness.

Realizing the gaps exposed by this review, this study seeks to examine the presence of SDT's three basic psychological needs of autonomy, competence, and relatedness among recipients of ACT services. Specifically, the study seeks to examine whether or not there exists a relationship between satisfaction of SDT's basic psychological needs and client satisfaction. Ryan and Deci's (2017) findings suggest the satisfaction of one's basic psychological needs is supportive of a person's optimal healthy behavioral and psychological functioning. A client's general level of satisfaction with services is more likely to be realized if the person's basic psychological needs have been satisfied.

Self-Determination Theory and the Motivation Continuum

Self-determination theory (SDT) is a broad motivational theory of personality, which utilizes an organismic theory that incorporates a conceptualization of intrinsic and extrinsic motivating factors (Deci & Ryan, 2008). It is a theory that "[...] analyzes the effects of events relevant to the initiation and regulation of behavior in terms of their meaning for the person's self-determination and competence" (Deci & Ryan, 1985, p. 9). Earlier work of this comprehensive theory of motivation was originally developed by Edward Deci with his research on intrinsic motivation in 1970, and on competence in 1975 (Deci, 1971). Edward Deci and Richard Ryan began collaborating in the 1980s to develop the theoretical framework that represents the motives of competence, relatedness, and autonomy (Sheldon, Williams, & Joiner, 2000). SDT has revealed "all individuals have natural, innate, and constructive tendencies to develop an ever more elaborated and unified sense of self" (Ryan & Deci, 2002, p. 5). This

finding differed from the dominant viewpoint during that time, which looked at behavior as being driven from reinforcement contingencies such as rewards or punishment.

The idea that people possess an intrinsic motivation to engage in tasks not associated with any type of reward or punishment established a new theoretical foundation to evaluate what drives motivation (Ryan & Deci, 2002). SDT research has revealed that use of rewards or contingencies has actually thwarted movement toward intrinsic motivation, and that “[...] compliance lasts only as long as the contingency is in effect” (Ryan, Plant, & O’Malley, 1995, p. 282). Findings from SDT research could play a valuable role to inform the provision of ACT services and enhance recovery-oriented practice interventions. ACT staff frequently utilizes various types of contingency management strategies, which are coupled with other cognitive behavioral therapy (CBT) and illness management and recovery (IMR) evidence-based practices per ACT fidelity standards (Teague, Mueser, & Rapp, 2012). Another key distinction between SDT and other theories of motivation is that SDT recognizes the type of motivation, such as autonomous and controlled motivation, plays a more significant role in regard to volition than the amount of motivation (Deci & Ryan, 2008).

There appears to be no known published literature regarding the application of SDT to the justice involved clients and involuntary clients and literature regarding application of SDT to empirically supported mental health treatments is quite sparse (Sheldon, Williams, & Joiner, 2003). Deci and Ryan (2008) however, do offer some literature on the use of SDT as a motivational theoretical framework for psychotherapeutic interventions, which could help inform SDT’s application in practice settings such as ACT. SDT principles align with social work values and ethics by supporting the autonomy of non-voluntary clients whom are often individuals coerced to treatment by the courts or legal authorities. A study of voluntary and non-

voluntary clients receiving outpatient alcohol treatment showed that people who self-referred had the lowest dropout rates and those who were coerced into treatment had the highest dropout rates (Ryan, Plant, & O'Malley, 1995). The promotion of external or internal locus of causality can still lead to an internalized motivation to engage in treatment, even by those coerced into treatment (Vansteenkiste & Ryan, 2013). This is an important SDT finding that can help staff understand how they can best use autonomy-supportive interventions to enhance client engagement. This is accomplished by providing information and listening in an autonomy-supportive manner, verses use of controlling interventions, which will serve to enhance outcomes by means of helping them internalize their motivation while simultaneously respecting their self-determination (Deci & Ryan, 2011; Ryan, Plant, & O'Malley, 1995).

SDT is closely aligned with social work's professional standard of ethics and values. The National Association of Social Workers (NASW) *Code of Ethics* (2008) and SDT outline dignity, worth of the person, and self-determination as important tenets for practice. These are among some of the values and ethical principles in which the empirical support from SDT provides a framework to help promote and respect a client's dignity and self-determination. SDT's organismic approach assumes that humans act on their internal and external environments, and that behavior is influenced by both the self and the environment as humans thrive toward development of a unified self (Deci & Ryan, 1985). This organismic approach represents a holistic standard that looks at how motivational variables are impacted by conditions within the environment that either "[...] facilitate verses hinder effective and reliable developmental change" (Deci & Ryan, 1985, p. 115).

SDT empirical research has demonstrated how people will exhibit greater psychological health and well-being when their capacity to strive toward intrinsic autonomy is most supported.

A person's self-determination is promoted as a person internalizes and integrates external regulations or works toward strengthening intrinsic motivation, which helps them exhibit higher levels of engagement, "[...] vitality, and creativity in their life activities, relationships, and life projects" (Deci & Ryan, 2012, p. 85). This theory provides a framework to support and better understand how a practitioner can best support and promote a client's self-determination as stated in the *Code of Ethics* (2008). It embraces the idea that all humans have a drive toward an autonomous state and takes notice of how it can help inform how to support a person in either fully autonomous or controlled states (Deci & Ryan, 2012).

Evaluating the presence of SDT's basic psychological needs among ACT teams provides a mechanism to evaluate where increased intervention methods are needed to support a person's greater internalization which is "[...] predictive of enhanced physical, psychological, and social wellness" (Vansteenkiste, Niemiec, & Soenens, 2010, p. 15). ACT team participants fall along the range of the motivational continuum and many individuals will be mandated through externally regulated sources such as criminal justice entities as well as through mental health commitments. SDT's tenets offer staff a framework to support a person's autonomy by means of helping the client experience a sense of ownership and personal value to the treatment experience. This is done in hopes that they will eventually move from their status as an externally motivated (external regulation) person to a place of full internalization (integrated regulation), which could lead to the development of intrinsic motivation.

Basic Psychological Need Satisfaction Scale

This broad motivational theory of personality named SDT describes how autonomy support fosters motivation and internalization of a behavior. There is extensive evidence to support this claim (Ryan & Deci, 2008). Empirically supported research has supported SDT's

position that human motivation is driven by psychological needs of competence, autonomy, and relatedness (Deci & Ryan, 2000). These concepts derive from SDT's assumption that "[...] when satisfied yield enhanced self-motivation and mental health and when thwarted lead to a diminished motivation and well-being" (Ryan & Deci, 2000, p. 68). The key concepts of competence, autonomy, and relatedness within the SDT framework is represented on the continuum of motivational and regulatory styles (autonomy continuum) that has been applied and replicated across vastly different types of individuals, groups, cultures, and ages in empirical research designs (Ryan & Deci, 2006).

The Basic Psychological Need Satisfaction Scale (BPNS) is a survey instrument created by authors of SDT and for this study it is used to measure the degree in which SDT's features of positive assumptions of autonomy, competence, and relatedness of human nature might be experienced by recipients of ACT services. SDT research has demonstrated that the presence of these key features helps to prevent or minimize coercion while looking at both intrinsic and extrinsic motivation along the motivational continuum of external, identified, and introjected as three types of extrinsic motivational factors (Sheldon, Williams, & Joiner, 2003). Extensive empirical literature supports this type of theoretical framework to inform practice interventions that ensure that the self-determination of the person is supported. The satisfaction of a person's basic psychological needs is a fundamental component to facilitate a person's success in ACT services as well as other models of treatment. If a person's basic psychological needs are satisfied, it is hypothesized that their overall satisfaction with services will be higher. This is measured through a different satisfaction scale called the Consumer Satisfaction Questionnaire (CSQ-8).

Consumer Satisfaction Questionnaire (CSQ-8)

The CSQ-8 is an empirically validated survey tool with robust psychometric properties such as higher levels of internal consistency ranging from 0.83 to 0.93 on Cronbach's coefficient alpha, compared to other satisfaction questionnaires (Attkisson & Zwick, 1982; Attkisson & Green, 1996; Roberts, Pascoe, & Attkisson, 1983). The clients' level of satisfaction is the dependent variable for this study, therefore it is critical to select a well-tested measurement tool that has both face validity as well as strong psychometric properties. The CSQ-8 has also been tested empirically and shown to have high internal consistency across cultures (Brey, 1983). Studies revealed how a client's satisfaction or dissatisfaction with a service will have a significant impact on behavioral consequences and client treatment choices (Greenfield & Attkisson, 1989; Roberts, Pascoe, & Attkisson, 1983; Ware & Davis, 1983).

Research has also revealed a relationship between a person's satisfaction with services to overall life satisfaction and well-being (Roberts, Pascoe, & Attkisson, 1983). This makes the CSQ-8 an excellent tool to use along with the BPNS instrument, which actually measures satisfaction of psychological well-being. It is highly probable for the two survey instruments to reveal similarities in regards to a high degree of satisfaction and high levels of perceived autonomy, competency, and relatedness. A client's level of satisfaction is predictive of treatment retention. Awareness of a client's level of satisfaction will assist ACT teams, as well as other models of care, to curtail services according to how to best meet the need satisfaction of persons served (Marchand et al., 2011; Säilä, Mattila, Kaila, Aalto, & Kaunonen, 2008). Scores from both the CSQ-8 and the BPNS scales will also serve to help identify where overall program improvement may be needed in order to increase positive client outcomes, identify where

additional training is needed, and provide client's more of voice to the type of care they are receiving.

Methods

Design, Setting, and Recruitment

A cross-sectional/explorative single-stage quantitative design was used for this study. Two surveys were completed face-to-face in the participant's living environment or setting of their choice. All 100 participants were recruited from six ACT teams residing in the urban metropolitan counties of Anoka, Ramsey, and Hennepin in the state of Minnesota. All participants were recruited from a convenience sample of voluntary individuals served by a total of six ACT teams, which consist of two teams in Hennepin county, three teams in Ramsey county, and one team in Anoka county. Five of the teams are full-size ACT teams serving between 90-100 clients and one team is a mid-size ACT team serving up to 74 clients. This brings the entire population to approximately 520 clients.

From this population, I sampled 100 voluntary participants from all of the six teams. A report for each team was generated from the client's electronic healthcare record and exported into an Excel document. The report includes the client's name, telephone number, and address. The Excel document was emailed to the team leader for each ACT team along with an explanation of the study and request to highlight clients whom they believe may be interested in participating in the study based upon clinical judgment and their knowledge of the client. The staff were asked to not contact the client or assist with recruitment to avoid potential coercion. The ACT team leads sent back the highlighted Excel document to the principle investigator. Clients highlighted in yellow were contacted by telephone to ascertain interest in voluntary participation in a research study.

The researcher provided a brief explanation of the study, requested their voluntary participation in the study, and were offered a five-dollar gift card if they chose to participate. They were assured that this study is for research purposes only, that it is not connected to their ACT services, and that participation (or declination to participate) will in no way impact services with their ACT teams. Participants were also informed that all identifying data will remain confidential, participation is voluntary, and they can opt out from completing the surveys at any time before or during completion of survey. Individuals who chose to participate received the five-dollar gift card regardless of whether they opted out prior to completion of the surveys. There were no participants who opted out prior to completion.

All participants provided written informed consent. Three research assistants completed the Human Subjects Research Training for Social-Behavioral-Educational Researchers through the Collaborative Institutional Training Initiative (CITI) Program, and provided assistance interviewing participants using the two surveys. The research assistants have no professional relations with potential participants to avoid unintentional coercion or influence. University of St. Thomas' Institutional Review Board (IRB) approved this study following a full board review. The executive director for both agencies reviewed and approved the study following IRB approval.

Measures

Data was collected from the clients' electronic healthcare record after receiving permission from the executive director. Data collected includes ethnicity, gender, age, mental health diagnosis, level of education, number of years on the ACT team, and county of residence. The same data was also collected by client self-report during the face-to-face meetings. Clients under guardianship were not selected to participate due to time limitations, the need to

acquire additional consent from their guardians, and assuring client's capacity to consent. The independent variable is the level of belief that self-determination is being supported and the dependent variable is the participants' level of satisfaction with ACT services. Two surveys were administered to the 100-client sample for the independent and dependent variables during face-to-face visits with the clients in their home living environments or location of their choice. The timeline for the study began on August 29, 2017 following IRB approval. Participants signed the informed consent forms and completed the measures in their preferred locations within the county delimitations.

Basic psychological needs scale (BPNS). The level of belief that self-determination is being supported was measured using the basic psychological needs scale (BPNS), which consists of 21 items rated on a 7-point Likert scale of questions, anchored from 1 as not at all true, 4 as somewhat true, and 7 as very true (Deci & Ryan, 2000). Nine of the 21 items worded in a negative direction were reverse scored, and then each subscale was averaged to calculate the items on the 7-point scale with higher averaged numbers being "more true" than lower averaged numbers. As stated earlier, a person's satisfaction of basic psychological needs of autonomy, competency, and relatedness contributes toward an actualization of intrinsic motivation and internalization. These are key ingredients for optimal growth and psychological well-being; therefore, higher averaged scores are indicative of greater satisfaction in each domain (Deci & Ryan, 2000; Gagné, 2003; Gagne & Deci, 2005).

The BPNS scale consists of seven items in the autonomy domain, six items in the competency domain, and eight items in the relatedness domain. An average for each domain score was calculated following reverse scoring procedures. The BPNS is one of three scales still being researched and has demonstrated reliable face and content validity. Extensive SDT

empirical research has revealed that environmental factors supportive of autonomy, competence, and relatedness yield positive psychological health, well-being, and enhancement of motivation (Deci & Ryan, 2000). There are also a number of studies in the areas of sports, exercise, work, education, prosocial behavior, and overall well-being that have demonstrated connections between increased need fulfillment and motivation with satisfaction of the three domains of autonomy, competency, and relatedness (Deci et al., 2001; Gagné, 2003; Gagne & Deci, 2005; Reinboth, Duda, & Ntoumanis, 2004; Sheldon & Bettencourt, 2002; Vallerand, Fortier, & Guay, 1997).

Client satisfaction questionnaire (CSQ-8). The level of satisfaction with ACT services was measured using the client satisfaction questionnaire (CSQ-8). The CSQ-8 contains eight items rated on a 4-point Likert scale measuring quality of service, type of service, extent service met a person's needs, whether the person would recommend the service, degree of satisfaction with the service, helpfulness of service, overall satisfaction with the service, and whether the person would return to the program to receive the same service (Attkisson & Zwick, 1982). Participants were asked to rate their level of satisfaction of ACT services on the 4-point Likert scale, which could range from eight to 32. Higher scores indicated a higher degree of satisfaction with services. The CSQ-8 has exhibited positive reliability and validation testing. Research in outpatient mental health program settings have revealed high levels of inter-item and inter-total correlations and a high coefficient alpha of .93 and .92 for a high degree of internal consistency in studies measuring client and therapist satisfaction (Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; Nguyen, Attkisson, & Stegner, 1983). The CSQ-8 has also demonstrated high reliability and validation testing in studies across different cultures and health care environments (Matsubara et al., 2013).

Data Analysis

Data was entered into the IBM Statistical Package for the Social Sciences 25 (SPSS 25) software and cleaned for analysis. Descriptive statistical analysis was conducted to present the demographic variables, the CSQ-8 measure of the dependent variable, and the BPNS measure of the independent variables regarding satisfaction of basic psychological needs for each subcategory of autonomy, competence, and relatedness. Descriptive analysis was conducted for the mean scores, standard deviations, and range for the variables. The Pearson coefficient of correlational analysis was conducted to examine the associations between the quantitative independent and dependent variables. A regression analysis was conducted to examine the power of self-determination to predict satisfaction with ACT services. The Kolmogorov-Smirnov test was used to assess the distribution of the sample and the Durbin-Watson statistic was used to check for autocorrelation in the residuals from the regression analysis. Finally, a multiple linear regression statistical analysis was conducted to look at the relationship between the dependent and independent variables in the study. The covariates of education, age, and years on the ACT team were run as descriptive statistics to identify the mean and standard deviation.

Results

Table 1 shows the descriptive statistics for all variables based on the participants in the study ($n = 100$). The participants were between 21 and 67 years of age ($M = 42.23$, $SD = 12.74$), had between five and 16 years of education ($M = 12.05$, $SD = 1.87$), and were on the ACT team for an average of approximately four and a half years ($M = 4.05$, $SD = 3.33$). The majority of the participants were male and, of those who specified their ethnicity, most were white.

Table 2.1

Descriptive statistics for all variables.

Variable	<i>n</i>	%	<i>M</i>	<i>SD</i>	Skewness	Kurtosis
Ethnicity	100	100			-.46	-.12
African American	11	11				
Asian	3	3				
Hispanic	1	1				
Native American	1	1				
Caucasian	30	30				
Unspecified	54	54				
Gender	100	100			1.30	-.31
Male	77	77				
Female	23	23				
Education	100	100	12.05	1.87	-.18	3.24
Age	100	100	42.23	12.74	.32	-1.09
Years on ACT team	100	100	4.05	3.33	.92	-.10
Satisfaction	100	100	26.69	4.09	-1.09	1.57
Autonomy	100	100	5.08	1.04	-.31	-.11
Competence	100	100	4.92	1.04	-.05	-.66
Relatedness	100	100	5.01	1.13	-.58	.25

Tests of Assumptions

The univariate normality of the variables was examined through assessment of skewness and kurtosis estimates. In other words, satisfaction, autonomy, competence, and relatedness were

each within appropriate limits for assuming univariate normality (± 2 ; Chou & Bentler, 1995).

This indicates that the distributions of each of the variables were approximately normally distributed.

Primary Analyses

Bivariate analyses (Pearson's correlations) were conducted to test the linearity between the independent and dependent variables, the results of which are reported in Table 2.

Table 2.2

Bivariate associations between independent and dependent variables

Variable	(1)	(2)	(3)
(1) Satisfaction			
(2) Autonomy	.33* [.14, .49]		
(3) Competence	.24* [.05, .42]	.54** [.38, .66]	
(4) Relatedness	.45** [.28, .59]	.52** [.35, .64]	.39** [.21, .55]

Note. Brackets represent 95% confidence intervals.

* $p < .05$, ** $p < .001$.

Each of the independent variables correlated significantly with the dependent variable, satisfaction. In particular, satisfaction positively and significantly correlated with relatedness, $r = .45$, 95% CI [.28, .59], $p < .001$, and autonomy, $r = .33$, 95% CI [.14, .49], $p = .001$, both of which were medium in effect size (Cohen, 1992). A statistically significant positive correlation was also found between satisfaction and competence, $r = .24$, 95% CI [.05, .42], $p = .015$, which was small-to-medium in effect size. The correlations between competence, autonomy, and relatedness were positive and statistically significant ($p < .05$; see Table 2).

A multiple linear regression analysis was conducted to test whether the extent to which autonomy, competence, and relatedness predicted satisfaction. First, the hypothesis testing assumptions was examined. As indicated above, the dependent variable was found to be normally distributed. The variance inflation factor (VIF) statistics for each independent variable were between 1.40 and 1.67, which indicated that there were no multicollinearity issues with the independent variables. An examination of a standardized predicted value versus standardized residual value scatterplot revealed the randomization of errors assumption was satisfied and there were no homoscedasticity issues (see Figure 1).

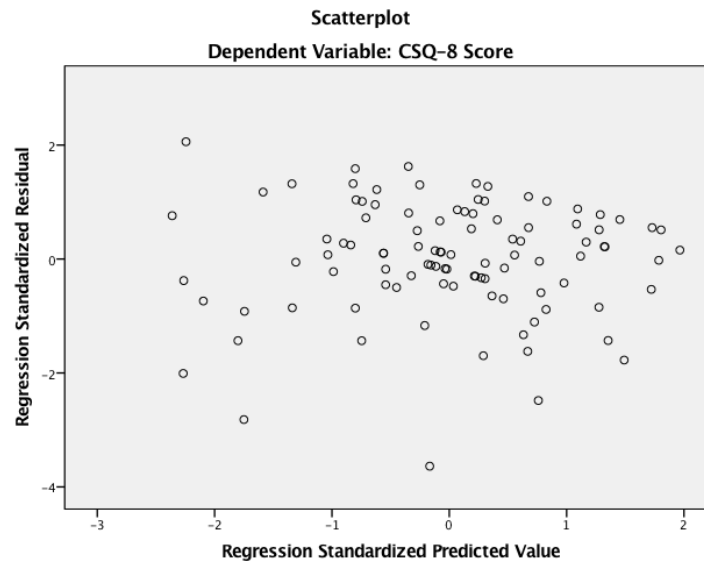


Figure 2.1. Standardized Predicted Value Scatterplot of CSQ-8 Scores

A residual boxplot indicated that there were no substantial residual outliers, and that the residuals were normally distributed, Kolmogorov-Smirnov = .08, $p = .142$.

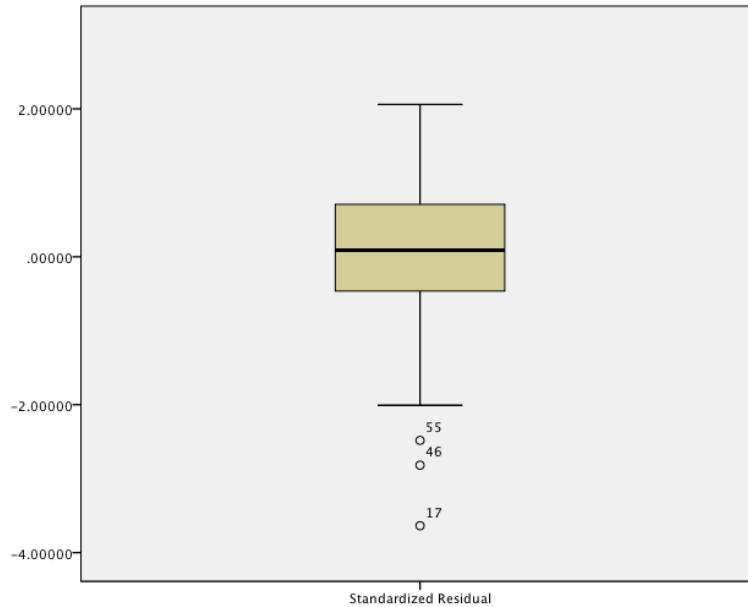


Figure 2.2. Standardized Residual Value Scatterplot

The multiple linear regression analysis revealed the model was significant (see Table 2.3), indicating that autonomy, competence, and relatedness accounted for approximately 22% of the variability in satisfaction. Examining the coefficients, relatedness, but not autonomy, or competence, significantly predicted satisfaction. The Beta coefficients (β) represent standardized values of the predictive strength of each independent variable, which can be compared directly to one another. Higher absolute values indicate that the independent variable is a stronger predictor of the dependent variable, and the size and direction of the values correspond with t -values (i.e., higher t -values are associated with higher Beta coefficients). Therefore, relatedness was the strongest and sole significant predictor of satisfaction.

Table 2.3

Multiple linear regression analyses predicting satisfaction.

Predictors	DV = Satisfaction			
	B [95% CI]	SE	β	t (p-value)
Autonomy	.45 [-.47, 1.36]	.46	.11	.97 (.334)
Competence	.13 [-.72, .98]	.43	.03	.30 (.767)
Relatedness	1.38 [.61, 2.15]	.39	.38	3.54* (.001)
Constant	16.90 [12.58, 21.22]	2.18		7.76 (< .001)
R^2 (SE)	.22 (3.68)			
F	8.80 (3, 96)			
Residual (Min, Max)	-13.37, 7.57			

Note. * $p = .001$.

The resultant regression equation was $\hat{y} = 16.90 + .45*Autonomy + .13*Competence + 1.38*Relatedness + ei$. Therefore, a one-unit increase in autonomy is associated with a .45 increase in satisfaction, a one-unit increase in competence is associated with a .13 increase in satisfaction, and a one-unit increase in relatedness is associated with a 1.38 increase in satisfaction.

Discussion

The purpose of this study was to evaluate the potential relationship between ACT client's level of satisfaction with services and satisfaction of SDT's basic psychological needs of autonomy, competence, and relatedness. The researcher hypothesized that (a) autonomy,

competence, and relatedness would be correlated with satisfaction and (b) autonomy, competence, and relatedness would each be significant predictors of satisfaction. Based on the results, hypothesis (a) was supported given that at least one the variables of relatedness was a statistically significant predictor of satisfaction. Hypothesis (b) was only partially supported, given relatedness, but not competence or autonomy were significant predictors of satisfaction. According to the results relative to hypothesis (a), each component of SDT's basic psychological needs are associated with higher levels of satisfaction. This coincides with research that has identified a connection to need satisfaction and both well-being and general life satisfaction (Johnston & Finney, 2010; La Guardia, Ryan, Couchman, & Deci, 2010).

The descriptive statistics of this study indicated a large standard deviation for the variables of education, age, years on the ACT team, satisfaction, autonomy, and competence. This is indicative of a wide range between the values, which is especially true for the age variable ($M = 42.23$, $SD = 12.74$) due to an age outlier of 21 years, whereas the average age was closer to 45 years for all study participants. The relatedness variable had the lowest standard deviation indicating a closer range between the scores. Relatedness was also the most closely associated variable with client satisfaction with a statistically significant relationship ($p = .001$). There were no statistically significant relationships between client satisfaction and autonomy; however, the descriptive statistics show high mean scores for each subscale of autonomy ($M = 5.08$, $SD = 1.04$), competence ($M = 4.92$, $SD = 1.04$), and relatedness ($M = 5.01$, $SD = 1.13$). This suggests that people reported high levels for each of these three subscales even though a statistically relationship was not connected to client satisfaction.

A larger sample size may indeed lead to more significantly significant results in future studies as SDT research has revealed that when one of the three basic needs are supported, such

as autonomy, the other basic psychological needs will also be supported. This means that people will be more engaged, exhibit increased psychological health and well-being, and be more satisfied with their treatment (Deci & Ryan, 2012; Deci & Ryan, 2015). The findings regarding relatedness do match one empirical study, which found that people with the diagnosis of schizophrenia were more driven by goals pertaining to relatedness and not by those concerning autonomy and competence (Gard et al., 2014). This contrasts with a different study, which found autonomy support to be more predictive of positive outcomes than the therapeutic alliance (relatedness) in psychotherapy settings (Zuroff, Koestner, Moskowitz, McBride, & Bagby, 2012). These two studies highlight the fact that there may exist differences regarding how the basic psychological needs underlying motivation and well-being manifest among different populations, such as people diagnosed with mental illness.

Strengths

The CSQ-8 scores for the participants in this study were quite high ($M = 26.69$, $SD = 4.09$), which is an average out of a total score of 32. This is indicative of a high level of client satisfaction across the sampled ACT teams, which suggests ACT staff are respecting client self-determination. The CSQ-8 questionnaire was also well received and understood by the clients in the study. Participants found it easy to identify their level of satisfaction for the eight questions. The study revealed useful information regarding the positive correlation between client satisfaction and one of the subscales of relatedness within the BPNS scale. There is much to be learned from the process of administering the BPNS scale and its goodness of fit with the SPMI population. There exist future research opportunities to validate a modified BPNS to include less complex language and ranking structures. For example, providing a phrase for each number such as a 1 for not at all true, a 2 for truer than not true, a 3 for a little true, a 4 for somewhat true, for

each number leading up to seven may help participant more clearly articulate where they identify along the continuum.

Limitations

The most significant limitation of this study is the small sample size ($n = 100$), which interferes with a normal distribution and limits the generalizability of the results. The small sample size also interfered with the ability to identify statistically significant relationships between the dependent variable of satisfaction and the independent variables of autonomy, competence, and relatedness. Also, the cross-sectional study design is not able to determine or imply causality. The actual results of the statistical analysis were also quite limited; therefore, it may be useful to frame this research as a pilot study to prepare for a larger-scale study of 200-300 participants. Despite the limited sample size for this study, a recent study concluded that a number as low as two subjects per variable could suffice for an accurate estimation of linear regression analysis (Austin & Steyerberg, 2015).

Another potential limitation was the possibility that study participants did not understand the one to seven continua on the BPNS scale. Many of the participants limited their answers to a 1 for not at all true, a 4 for somewhat true, or a 7 for very true. It was difficult for the participants to understand that they could answer anywhere along the continuum from one to seven. For example, many of the participants appeared confused when they were told that their answers can be slightly truer than somewhat true or slightly less true than very true. It may have been useful to create a laminated cue card with a one to seven range and allow the participant to mark where they see themselves along that continuum, which will then correspond with a number ranging from one to seven. Future studies could implement the use of a cue card in order to better assist participants understanding of the one to seven continua.

Conclusion

This is the first known study to assess the relationship between client satisfaction using the CSQ-8 and satisfaction of basic psychological needs using the BPNS scale among persons served by ACT teams. The study did not support a statistically significant relationship between level of satisfaction and satisfaction of autonomy or competence; however, it did identify a statistically significant relationship with relatedness. The results of this study partially support the hypothesis regarding a relationship between level of satisfaction with ACT services and satisfaction of basic psychological needs; however, the limited sample size, and weak associations between variables requires additional data collection and analysis to suggest such a connection.

The study can be better understood as a pilot project leading up to a larger scale analysis with a more significant sample size of 200-300 participants. Further research is needed to test the relationship between the measures of the BPNS and the CSQ-8. Future research should evaluate whether the BPNS is the most effective tool to administer to individuals with SPMI disorders due to its seemingly complex question structure and rating scale. Identification of treatment interventions associated with positive client satisfaction, wellness, and support of one's basic psychological needs will contribute toward improved program outcomes and client services.

Promoting Smart Decarceration Through Forensic Assertive Community Treatment

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Abstract

Smart decarceration is one of the 12 social work grand challenges put forth by the Council of Social Work Education, which calls for an initiative to decrease the number of people incarcerated and decrease rates of criminal recidivism. The Forensic Assertive Community Treatment model of care includes the deliberate integration of a client's supervising agent (parole officer) into the team as a means to bridge the gap between law enforcement and mental health in an effort to achieve the three interrelated outcomes associated with the promotion of smart decarceration. A conceptual overview of the application of self-determination theory to assertive community treatment, forensic community treatment, and a review of findings from the author's empirical research reveal how the core ingredients associated with this theoretical framework (autonomy, competence, and relatedness) can provide a lens to help staff respect a person's autonomy and self-determination, thereby helping them internalize motivation to move along the continuum of care. This paper provides an overview of the interactive workshop entitled "Promoting Smart Decarceration Through Forensic Assertive Community Treatment" presented at Council of Social Work Education's 63rd Annual Program Meeting.

Keywords: smart decarceration, forensic assertive community treatment, self-determination theory

Promoting Smart Decarceration Through Forensic Assertive Community Treatment

The Council on Social Work Education (CSWE) held its 63rd Annual Program Meeting (APM) entitled “Educating for the Social Work Grand Challenges” in Dallas, Texas from October 19 to October 22, 2017. This author presented an interactive workshop entitled “Promoting Smart Decarceration Through Forensic Assertive Community Treatment” from 7:30 A.M to 8:30 A.M on October 21, 2017 at CSWE’s 63rd APM. The presentation is a product representing research from my conceptual paper, applying self-determination theory (SDT) to assertive and forensic assertive community treatment models of care. Included was research from a cross-sectional or explorative cross-sectional quantitative design, which evaluated relationships between client satisfaction and satisfaction of basic psychological needs associated with SDT and future implications for an adaptation to outcomes associated with smart decarceration. Client satisfaction was determined using the CSQ-8, which is a measurement of client satisfaction with mental health services (Attkisson & Zwick, 1982). Satisfaction of basic psychological needs was determined through the Basic Psychological Needs Scale formulated from SDT to measure satisfaction of autonomy, competence, and relatedness which allows one to achieve optimal functioning and wellness when satisfied (Deci & Ryan, 2000).

The smart decarceration initiative is one of CSWE’s social work grand challenges. Findings from the from a cross-sectional/explorative single-stage quantitative research support the use of SDT as a theoretical framework to help mental health and criminal justice providers support clients’ movement along the motivational continuum, which assists them to internalize motivation to engage in changing behaviors. These findings demonstrate how an application of the tenets associated with SDT may provide the theoretical platform to decrease rates of

incarceration and recidivism, which is one of the outcomes associated with the smart decarceration initiative.

Overview of Interactive Workshop

The following learning objectives were identified for this interactive workshop:

1. Participants will develop an understanding of the assertive community treatment (ACT) and forensics assertive community treatment (FACT) models of care through comparison and analysis of the two models' fidelity instruments; this will include the ability to differentiate essential ingredients of an evidence-based practice.
2. Participants will be able to identify how FACT addresses the three interrelated outcomes associated with the promotion of smart decarceration, one of the grand challenges for social work.
3. Participants will learn how to apply individual and group practice interventions associated with the FACT model of care such as cognitive behavioral therapy.
4. Participants will become familiar with and learn how to apply self-determination theory to ACT, FACT, and/or other models of care in both criminal justice and mental health settings.

Presentation Proposal

Utilizing the self-determination theory (SDT) as a conceptual framework, this interactive workshop will introduce participants to the forensic assertive community treatment (FACT) model of care as an evidence-based practice. A brief review of the assertive community treatment (ACT) model will provide background and comparison to the emerging FACT community-based model of care. The FACT model addresses many of the 12 grand challenges for social work, such as the advancement of long and productive lives and closing the health gap.

However, the challenge to promote smart decarceration will be the focus for this workshop. The evidence-based practice of FACT, coupled with SDT as the conceptual framework, addresses three smart decarceration goals: Substantially reduce the incarcerated population in jails and prisons; redress racial, economic, and behavioral health disparities within the criminal justice system; and maximize public safety and well-being (Epperson & Pettus-Davis, 2017).

This interactive workshop will demonstrate the application of SDT as the theoretical framework for the FACT model of care to provide approaches supportive of client autonomy. SDT will also provide useful framework to help FACT staff respect a person's autonomy and self-determination. In this context, the individual experiences a sense of ownership and personal value to the treatment experience, which may eventually move from their status as an externally motivated (external regulation) person to autonomous motivation (Ryan, Lynch, Vansteenkiste, & Deci, 2011). The workshop will also demonstrate how the FACT model addresses Epperson and Pettus-Davis' (2017) guiding concepts for smart decarceration, which include the following: Changing the narrative on incarceration and the incarcerated, making criminal justice system-wide innovations, implementing transdisciplinary policy and practice interventions, and employing evidence-driven strategies.

Assertive community treatment (ACT) is an evidence-based service delivery model designed to serve individuals with a serious and persistent mental illness (SPMI) in their preferred living environment. This model of care was designed to provide integrated multidisciplinary care to individuals with high needs who require more intensive support to remain successful in the community (Allness & Knoedler, 2003). The FACT model utilizes the same framework as ACT; however, it includes additional criterion such as identification of criminogenic risk factors, exclusion to work only with justice-involved clients, partnership and

cross-training with criminal justice providers, and inclusion of evidence-based community correctional interventions along with traditional mental health evidence-based practices (Lamberti & Weisman, 2004, 2010).

The FACT model is designed to engage individuals who have not responded positively to traditional office-based models of mental health care or authorities in the criminal justice system. The client may experience assertive engagement approaches such as legal leverage as coercive if they are not implemented within a strength-based, recovery-oriented framework (Lamberti et al., 2014). Self-determination theory can provide an empirical foundation to facilitate practitioner use of interventions that support a client's thriving toward optimal healthy behavioral and psychological functioning, which embraces a client's autonomy (Ryan & Deci, 2017). Research has revealed that ACT teams are successful in reducing hospital recidivism. However, the model has not demonstrated the ability to reduce criminal recidivism, although persons with an SPMI diagnosis experience incarceration more frequently than hospitalization (Beach et al., 2013). Adaptations to the ACT model to include forensic components such as criminogenic risk factors and criminal justice evidence-based practices will address the issue of both hospital and criminal recidivism.

FACT teams establish and maintain close partnerships with the criminal justice community and partner directly with the client's supervising agent (probation or parole officer). Social workers engage in active collaborative partnerships with the criminal justice service providers with full disclosure and transparency to the client. Many FACT clients will be mandated by the courts to receive treatment; therefore, it will be important to support a client's autonomy and self-determination to support therapeutic rapport. The self-determination theory established that intrinsically motivated prosocial behavior is best supported when a person's

basic psychological needs are satisfied; whereas the opposite is true when a person's basic psychological needs are thwarted (Ryan & Deci, 2017).

Application of SDT within the FACT framework will ensure that clients' autonomy and self-determination are supported while also utilizing empirically supported treatments to ensure effective care. The model also supports decreasing rates of criminal recidivism, alternatives to incarceration, and rehabilitation rather than punishment (re-incarceration). This model directly addresses the greater societal problem of mass incarceration and will help people access rehabilitation rather than punishment (incarceration). It also advances the grand challenge for social work by providing services to a vulnerable group and offering realistic rehabilitative alternatives to break the cycle of criminal recidivism.

Discussion of Interactive Workshop

Introduction of objectives, agenda, outcomes, and objectives: Slides 1-6. Slides 1-3 comprise an introduction to the objectives and agenda for the interactive workshop, which include an introduction to the main concepts associated with assertive community treatment (ACT), forensic assertive community treatment (FACT), smart decarceration, the 12 grand challenges, self-determination theory (SDT), and the author's empirical research. The slides include a brief review of the ACT and FACT fidelity instruments and an introduction to how FACT addresses three interrelated outcomes associated with smart decarceration, which is one of the 12 grand challenges. An introduction to SDT demonstrated how it may be used as a theoretical framework to advance the grand challenge as well as how an integration of the theory into the ACT and FACT fidelity models will advance the effectiveness of the two empirically-supported treatments.

Slides 4-6 explained the three outcomes and four guiding concepts of smart decarceration, which include the following: A reduction in the number of individuals incarcerated in jails and prisons, a redress of social disparities among the incarcerated, a maximization of public safety and well-being, a call to challenge the narrative on incarceration and the incarcerated, a move to system-wide innovations in the criminal justice system, an implantation of transdisciplinary policy and practice interventions, and use of evidence-driven strategies to achieve outcomes (Epperson & Pettus-Davis, 2017). Slide number five further explains how the smart decarceration will require a paradigm shift among justice and rehabilitative communities as well as the public. Epperson and Pettus-Davis (2017) referenced the statistic, which places the U.S. as the leader in mass incarceration with a rate of 700 per 100,000 individuals who are incarcerated and vulnerable populations, such as people with mental illness, are impacted at disproportionate rates. Slide six identifies how the FACT model of care, coupled with SDT, can serve to achieve positive outcomes associated with the smart decarceration initiative.

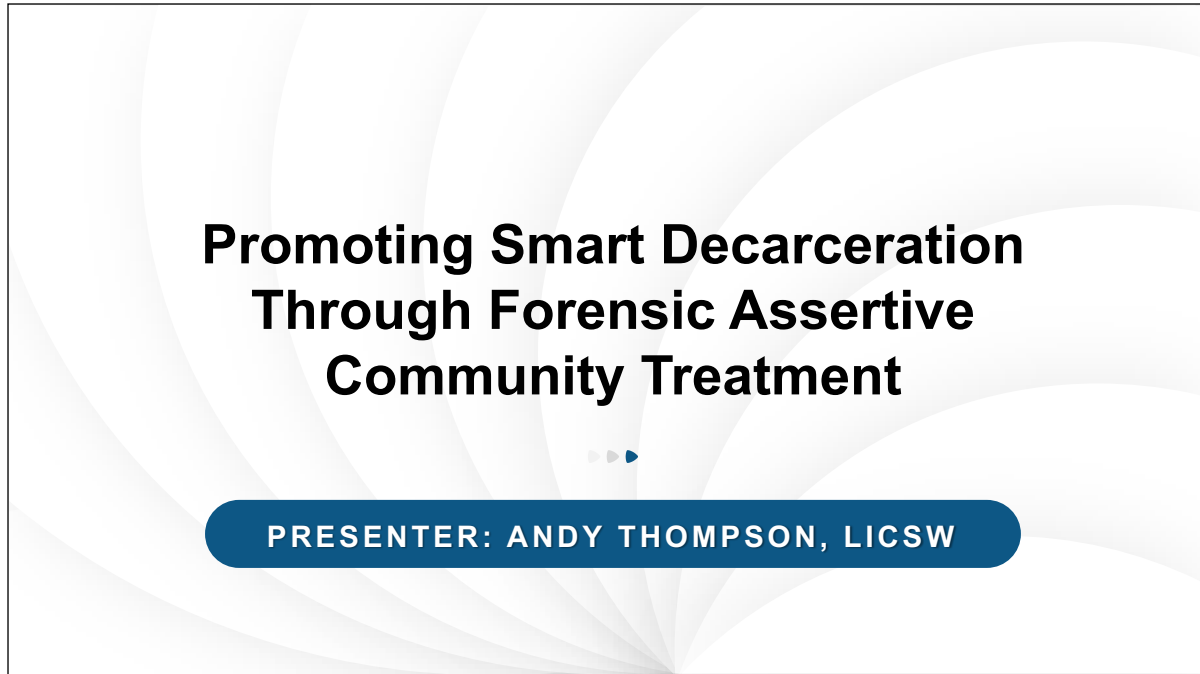


Figure 3.1. Slide one.

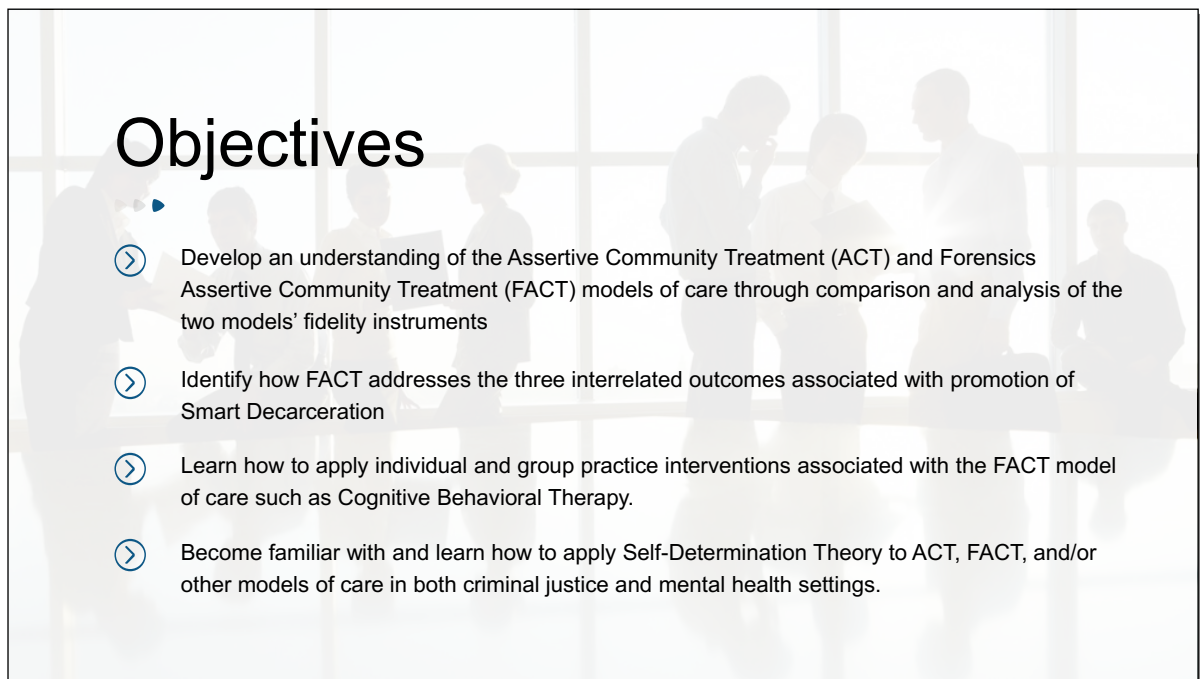


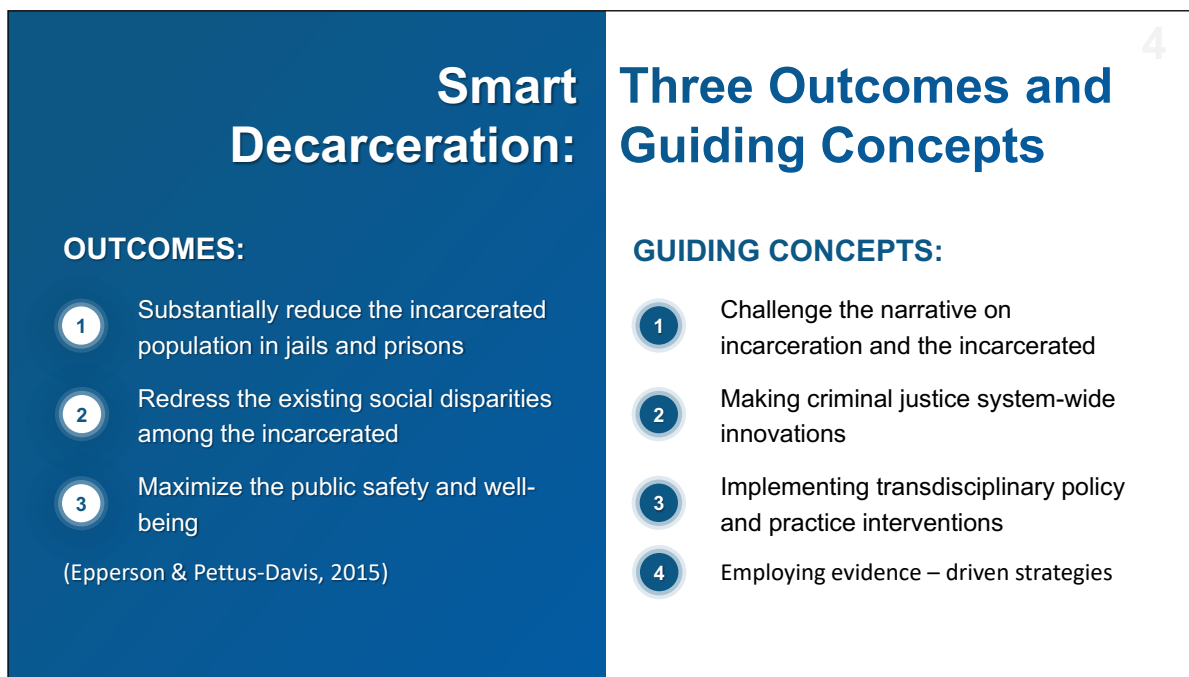
Figure 3.2. Slide two.



Agenda

- Brief overview of Smart Decarceration as one of the 12 Grand Challenges
- Statistics of people diagnosed with a serious mental illness (SMI) or a serious and persistent mental illness who are incarcerated
- Evidenced-based practices for criminal justice and mental health models of care
- Introduction to Forensic Assertive Community Treatment (FACT)
- Self-determination theory (SDT) as a conceptual and empirical framework
- Quantitative research regarding relationship between client satisfaction and the basic psychological needs of SDT
- Q & A

Figure 3.3. Slide three.



Smart Decarceration: Three Outcomes and Guiding Concepts

OUTCOMES:

- 1 Substantially reduce the incarcerated population in jails and prisons
- 2 Redress the existing social disparities among the incarcerated
- 3 Maximize the public safety and well-being

(Epperson & Pettus-Davis, 2015)

GUIDING CONCEPTS:

- 1 Challenge the narrative on incarceration and the incarcerated
- 2 Making criminal justice system-wide innovations
- 3 Implementing transdisciplinary policy and practice interventions
- 4 Employing evidence – driven strategies

Figure 3.4. Slide four.



Figure 3.5. Slide five.

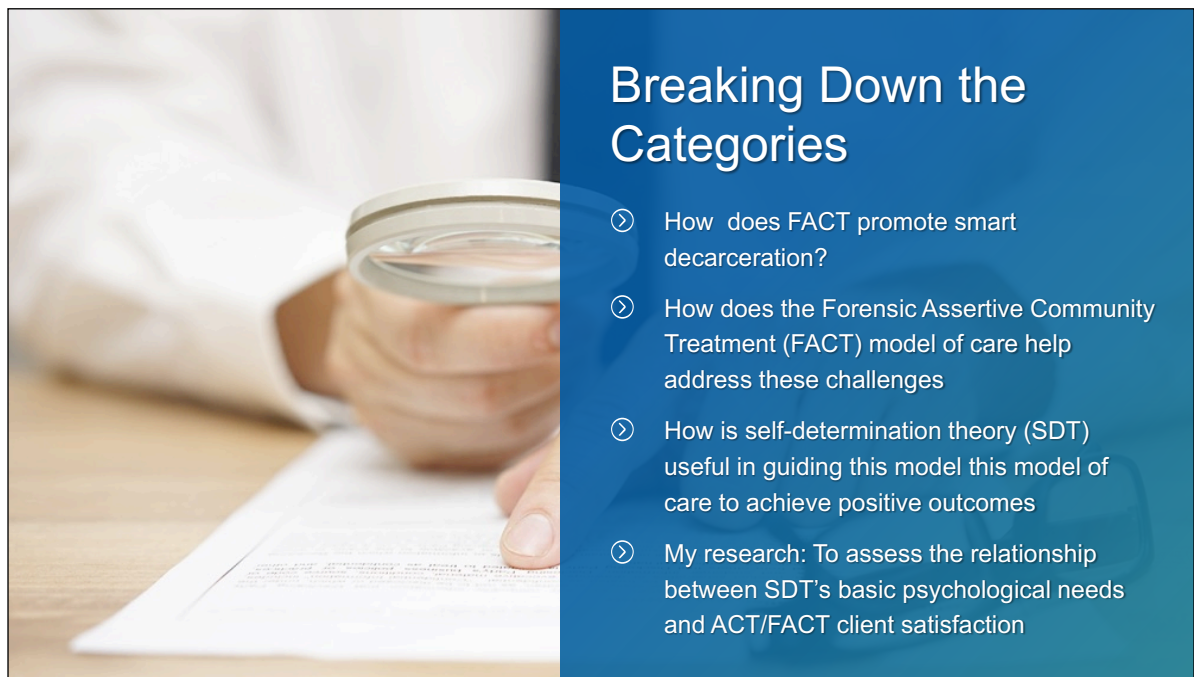


Figure 3.6. Slide six.

Statistics and evidence-based core correctional practices: Slides 7-13. Slides 7-9

reference statistics regarding the disproportionate number of individuals (inmates) with a mental health disorder in prisons and jails. A Department of Justice survey of inmates in state and

federal correctional facilities and a survey of inmates in local jails conducted in 2004 found that the highest prevalence existed among local jails with over two thirds (64.2%) of inmates with a mental illness, 56.2% of inmates in state prison with a mental illness, and 44.8% in federal prison with a mental illness (Bureau of Justice Statistics, 2013). The surveys also found that fewer than half of the inmates with a mental health problem ever received treatment and a third or fewer received mental health treatment after admission (Bureau of Justice Statistics, 2013). Newer statistics from 2014 revealed that 383,300 individuals diagnosed with a severe mental illness were incarcerated, which is ten times the number of people in psychiatric hospitals (Kaeble, Glaze, Tsoutis, & Minton, 2016).

Slides 10-13 provide an overview of evidence-based core correctional practices including the risk needs-responsivity (RNR) model as well as the good lives model. The evidence-based core correctional practices utilize a variety to empirically driven interventions such as cognitive-behavioral therapy, thinking for change, moral reconnection therapy, yet the focus of many of these interventions mostly on the person's criminogenic risk factors and reward-cost contingencies, which do not take into account theories of human motivation (Duwe, 2017). The overview of core correctional practices transitioned into a listing of the following criminogenic risk factors is listed on slide 11 (Andrews & Bonta, 2011), in addition the additional risk factor of psychosis and mania added by Lamberti and Weisman (2010).

The RNR continuum from static risk to improved outcomes was discussed along with an explanation of specific interventions such as role-play, education of common thinking errors, and behavioral contracting. The interventions associated with RNR were compared to those of the good lives model, which is more inclusive of intrinsic motivation as an essential ingredient to behavioral change as well as primary and secondary goods, whereas Andrews and Bonta's RNR

model focuses more closely on reward-cost contingencies and pro-social behavior as a means to reduce criminal recidivism and criminal behavior (Yates & Ward, 2008; Ward, Yates, & Willis, 2012). The good lives model is more aligned with the tenets of sdt with its strong emphasis on human agency, autonomy, and relatedness (Ward, Yates, & Willis, 2012).

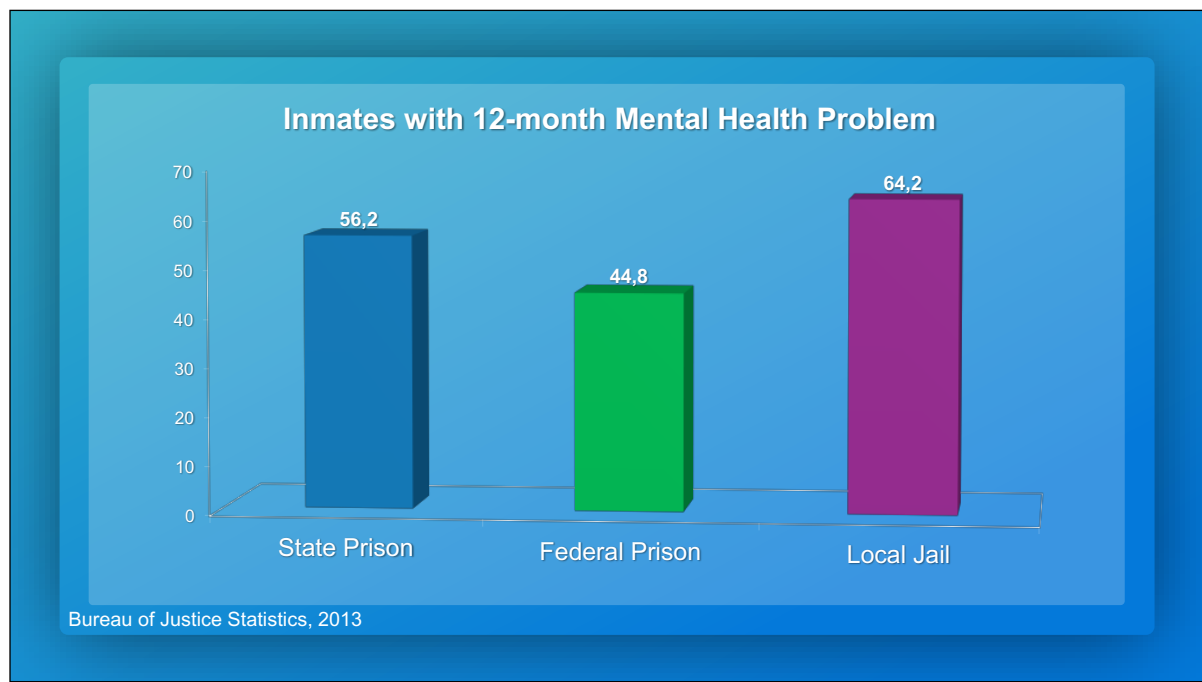


Figure 3.7. Slide seven.

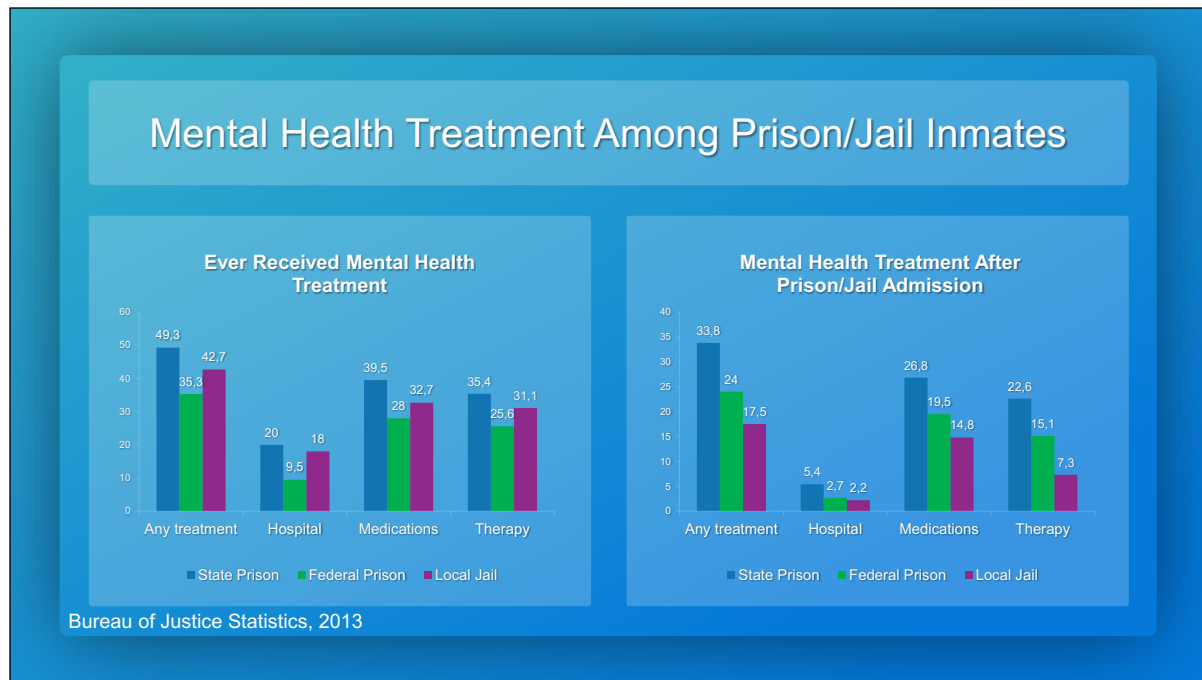



Figure 3.8. Slide eight.



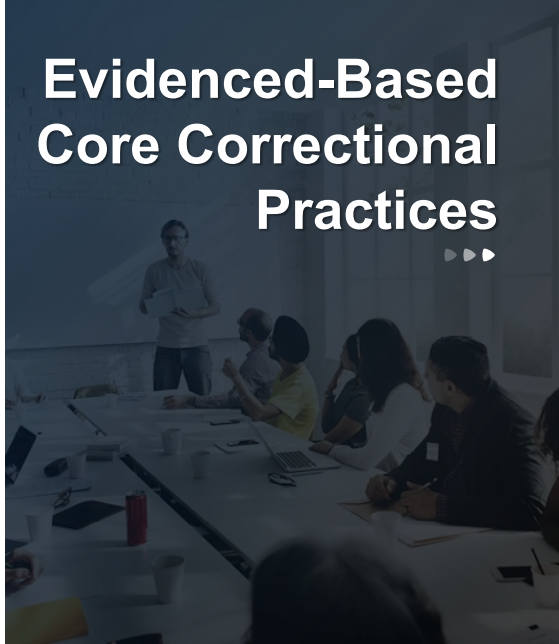
Individuals With SMI in Prisons and Jails: Newer Statistics

- ⌚ The "new asylums"
- ⌚ 20% of people in jail with a mental illness
- ⌚ 15% of people in prison with a mental illness
- 10 times the number of people in jails and prisons in the US compared to the people in psychiatric hospitals
- ⌚ SMI population twice as likely to be charged with facility rule violations
- ⌚ Substance use disorders four times higher than general population (Center for Behavioral Health Statistics and Quality, 2015).

(Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016; Kaeble, Glaze, Tsoutis, & Minton, 2016; Torrey, Kennard, Lamb, Eslinger, Biasotti, & Fuller, 2014)

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Figure 3.9. Slide nine.



Evidenced-Based Core Correctional Practices

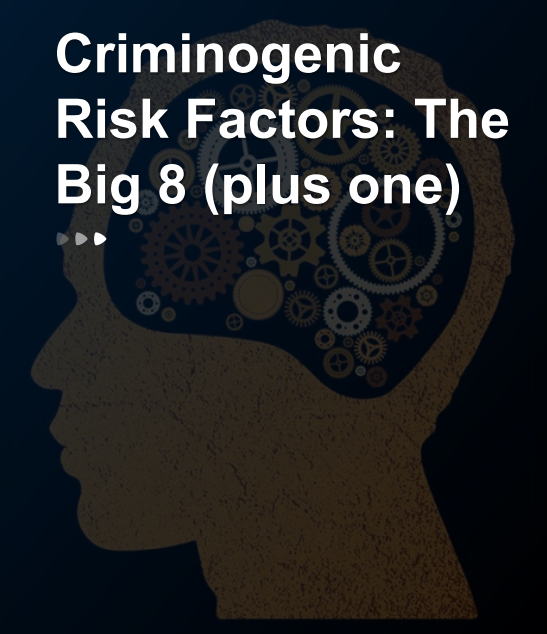
10

- Assess actuarial risk, needs, and responsivity (R&R)
- Enhance intrinsic motivation (yes!)
- Target interventions
- Train staff in cognitive-behavioral interventions
- Apply positive reinforcements
- Engage ongoing support in communities
- Measure processes and practices (Fidelity)
- Provide feedback—use data

Figure 3.10. Slide 10.

- History of antisocial behavior
- Antisocial cognition
- Social support for crime
- Antisocial personality
- Family/marital problems
- Work/school problems
- Lack of healthy recreation
- Substance use
- Psychosis and mania (Lamberti & Weisman, 2015)

Amdreus & Bonta, 2010



Criminogenic Risk Factors: The Big 8 (plus one)

Figure 3.11. Slide 11.

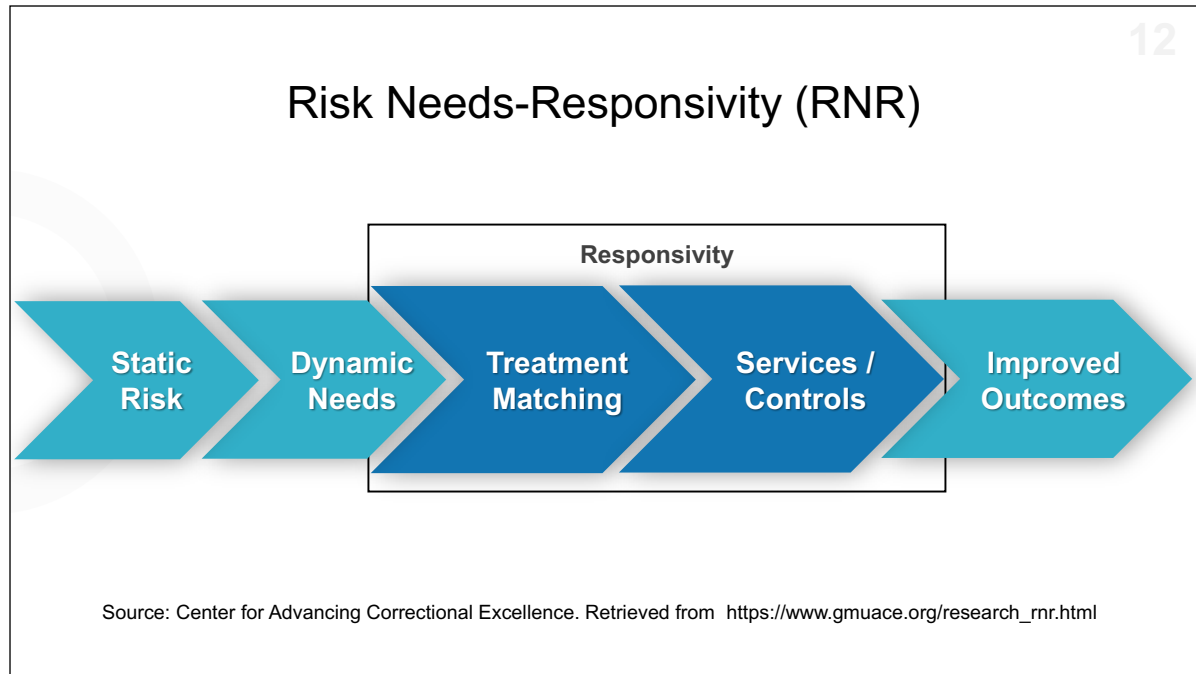


Figure 3.12. Slide 12.

The Good Lives Model

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- ④ “GLM promotes prosocial behavior both that has the possibility to reduce criminal behavior and that provides the individual with an opportunity to live a satisfying life, the latter with which the RNR does not concern itself. The GLM, therefore, acknowledges intrinsic motivation for behavior and goes beyond viewing the person as the passive recipient of behavioral contingencies, while also acknowledging the influence of these contingencies on criminal behavior” (Yates & Ward, 2008).
- ④ More than a series of reward–cost contingencies (predominantly for criminal behavior) and does acknowledge what individuals may be seeking to attain by their behavior—that is, what motivates them.

Figure 3.13. Slide 13.

Overview of forensic assertive community treatment: Slides 14-19. Slides 14-18 provided a brief overview of the FACT model of care including the ingredients of the FACT fidelity model. The overview provided an explanation of 15 separate categories of the FACT

fidelity model, which was built from the same criteria used for the ACT model of care. Additions to the model include inclusion of identification of criminogenic risk factors, working only with justice-involved populations, inclusion of evidence-based community correction practices, and fully integrated partnerships with criminal justice providers (Lamberti & Weisman, 2010).

Lamberti and Weisman's (2010) FACT fidelity model was briefly reviewed in slides 15-16 and elaborated upon in slides 17-18. Slide 19 presents information from an interview with a supervising agent regarding the benefits and positive experiences of a collaborative partnership with mental health FACT team members and members of the law enforcement community such as supervising agents. The key ingredients for a successful partnership were discussed as well as how each discipline can bring forward their area of expertise and engage in a collaborative decision-making process regarding the care and treatment of justice-involved individuals. The partnership helps address the paradigm shift referenced in the smart decarceration initiative such as moving from a punishment-based system to a rehabilitative model of care.



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Forensic Assertive Community Treatment

- FACT fidelity criterion includes 15 separate categories
- Same criterion as ACT with a forensic (criminal justice component)
- Legal leverage to promote movement along continuum of motivation and change
- Supportive of decreasing rates of incarceration and criminal recidivism
- Realistic rehabilitative alternatives to break the cycle of recidivism
- Incorporates EBP's from both mental health and criminal justice modalities (ie. R&R, GLM, CBT, TFT, etc)

Figure 3.14. Slide 14.

FACT Fidelity

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- Combined eligibility criteria
- Shared training
- Information sharing
- Written participation agreement
- Evidence-based mental health and substance use interventions




Figure 3.15. Slide 15.

FACT Fidelity

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- Evidence-Based Community Correctional Intervention
- Adherence Monitoring
- Shared Problem Solving
- Transition Procedures




Figure 3.16. Slide 16.

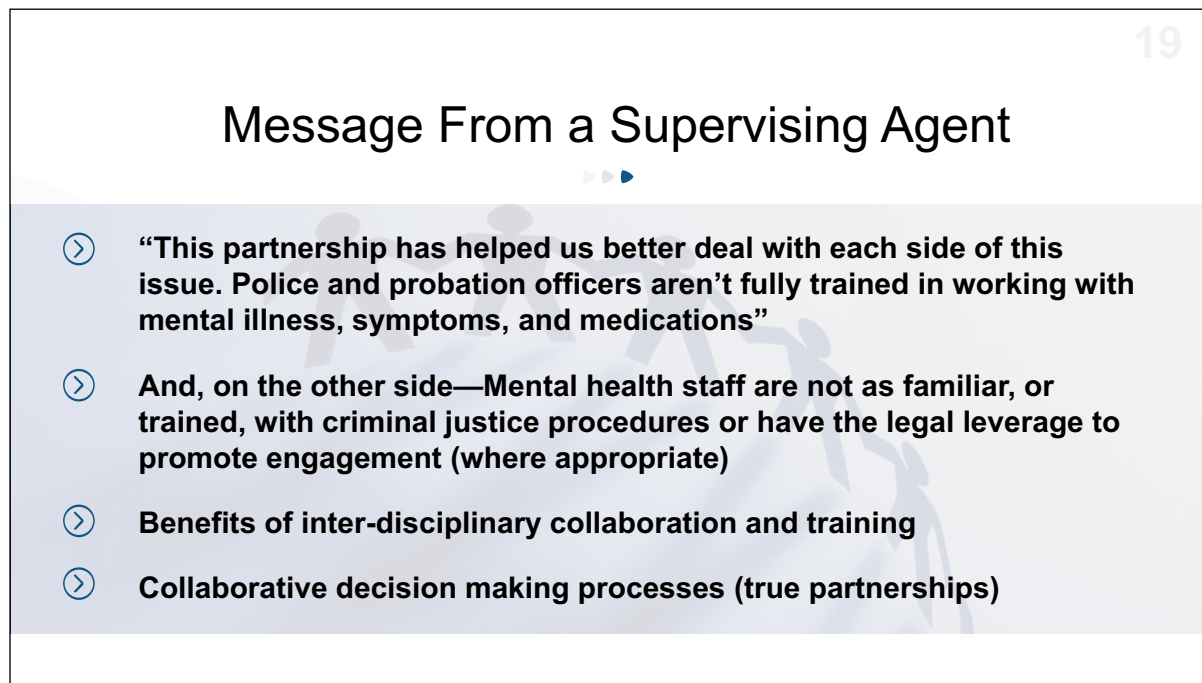
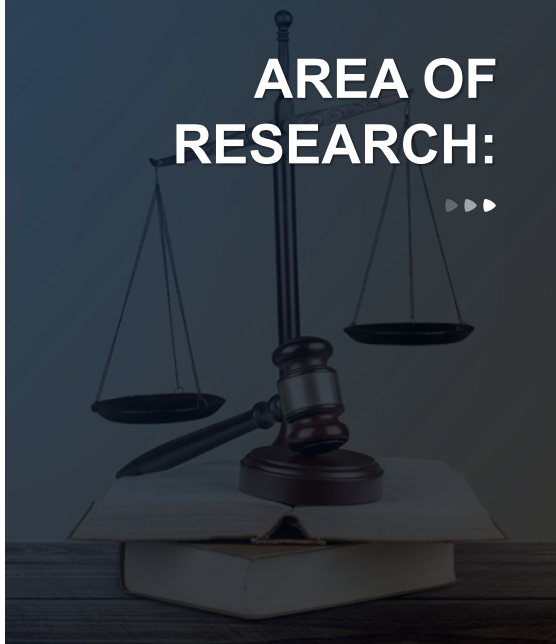


Figure 3.17. Slide 17.

Introduction research agenda and overview of SDT: Slides 20-29. The next section of the interactive workshop presentation includes an introduction to my conceptual article, which explains how SDT provides a framework for ACT and FACT teams to avoid coercive treatment approaches and engage in autonomy-supportive interventions supportive of an individual's movement along the continuum of motivation. The key concepts of competence, autonomy, and relatedness associated with SDT were explained. An explanation of SDT's autonomy continuum of motivational and regulatory styles offered opportunity to demonstrate how it is applicable across vastly different types of individuals, groups, cultures, and ages in empirical research designs (Ryan & Deci, 2006). The different critiques of ACT and FACT teams were explored as a means to identify how assertive engagement practices can be implemented in ways that are supportive of autonomy, rather than coercive or paternalistic. Subsequent slides provide graphic examples of the SDT tenets and framework to describe how the satisfaction of basic

psychological needs of autonomy, competence, and relatedness contribute to a person's effective functioning and wellness (Deci, Olafsen, & Ryan, 2017). Discussion of SDT's tenets offered the opportunity to explore how SDT can be used as a framework to support a person's autonomy by means of helping the client experience a sense of ownership and personal value to the treatment experience with the hope that they will eventually move from their status as an externally motivated (external regulation) person to a place of full internalization (integrated regulation), which could lead to the development of intrinsic motivation.

The graphic illustrations of SDT in slides 25-29 are explained in full detail. This included a breakdown of the types of extrinsic and extrinsic levels of motivation, and explanation of how autonomous motivation can lead to deeper learning, sustained engagement, and be implemented in ways that a person can be supported along the continuum from external to internal. Extrinsic sources of motivation can be implemented in ways that are autonomy supporting as opposed to use of control and punishment. Examples of externally regulated motivation were reviewed and examples from the FACT model of care were introduced. Specific examples include reference to the role of the supervising agent referring a client to a FACT team and how FACT team members work with clients who are not motivated or motivated through fear of punishment (incarceration) or through other sources of externally regulated methods such as involuntary commitment.



AREA OF RESEARCH:

20

Application of Self Determination Theory

- Overall scholarship framework: Conceptual, empirical research
- Smart Decarceration
- Self-determination theory (SDT) defined
- Autonomous and controlled motivation
- Forensic assertive community treatment (FACT)

Figure 3.18. Slide 18.

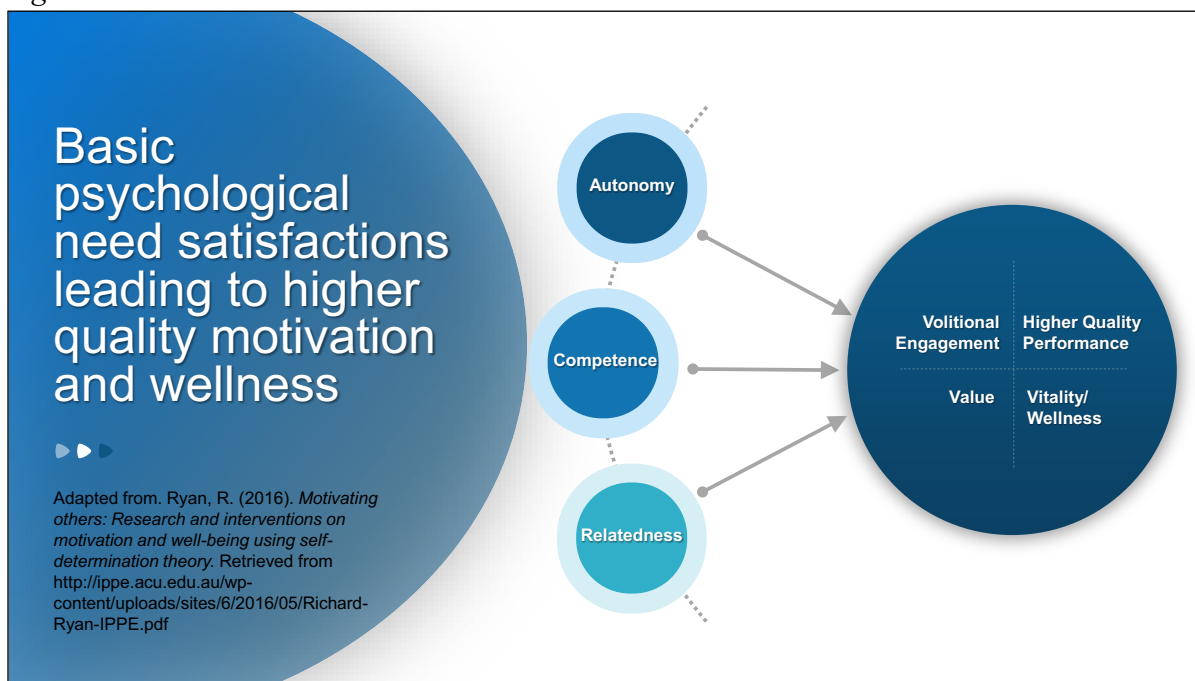


Figure 3.19. Slide 19.



Research

- ▶▶▶
- ① The key concepts of competence, autonomy, and relatedness within the SDT framework
- ① Humans innate tendency to seek out interconnectivity
- ① Optimal healthy behavioral and psychological functioning
- ① Basic psychological needs

Ryan & Deci, 2002; 2006; 2017

Figure 3.20. Slide 20.

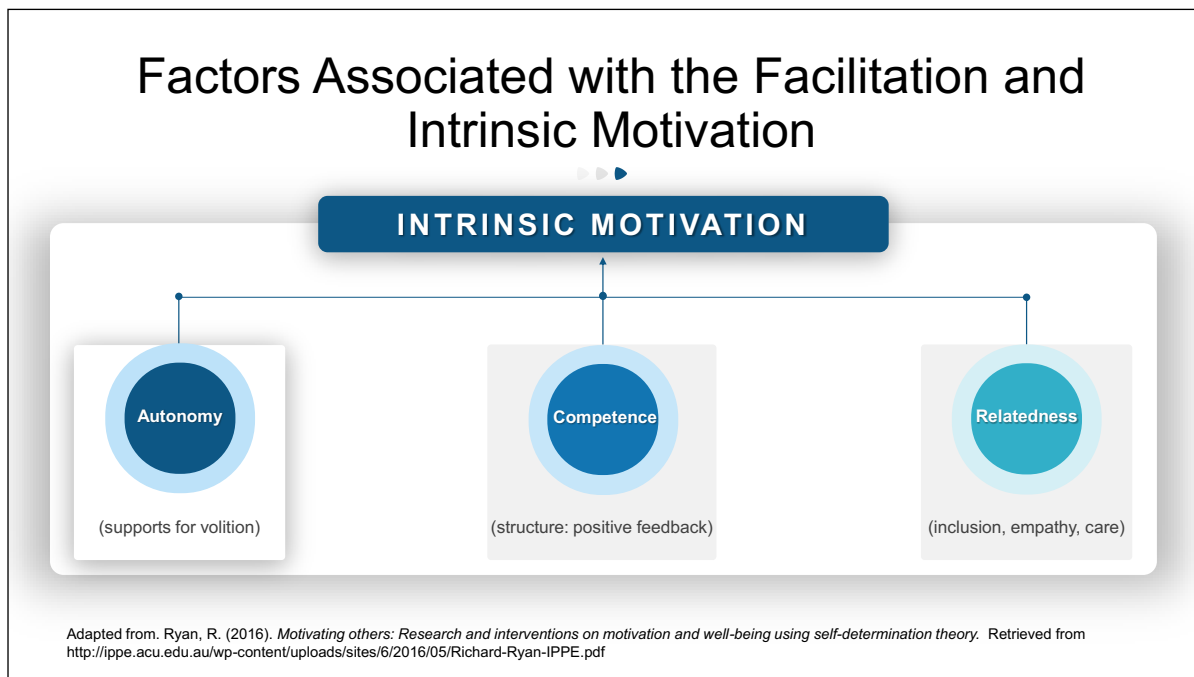
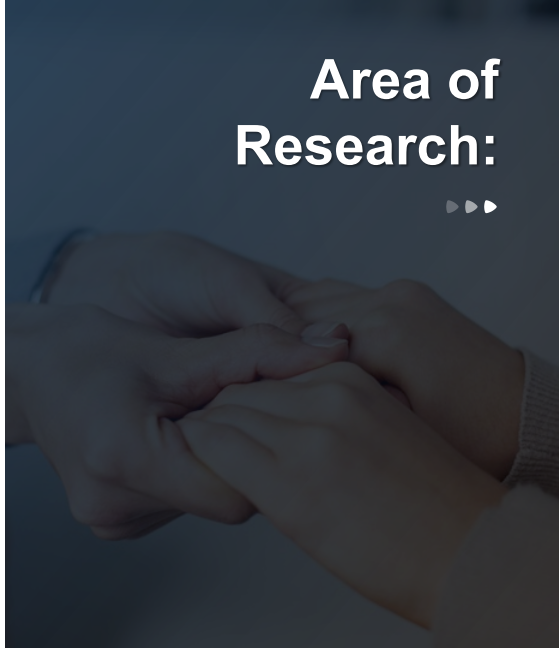


Figure 3.21. Slide 21.



24

Conceptual Article

- The assertive and forensic community treatment (ACT/FACT) models of care
- Assertive engagement approaches and coercion
- Critiques of the ACT (hence FACT) model of care as coercive or paternalistic
- Application of SDT to ACT and FACT and other empirically supported treatments (EST) to minimize coercion and assist peoples to move people along the continuum of motivation

Figure 3.22. Slide 22.

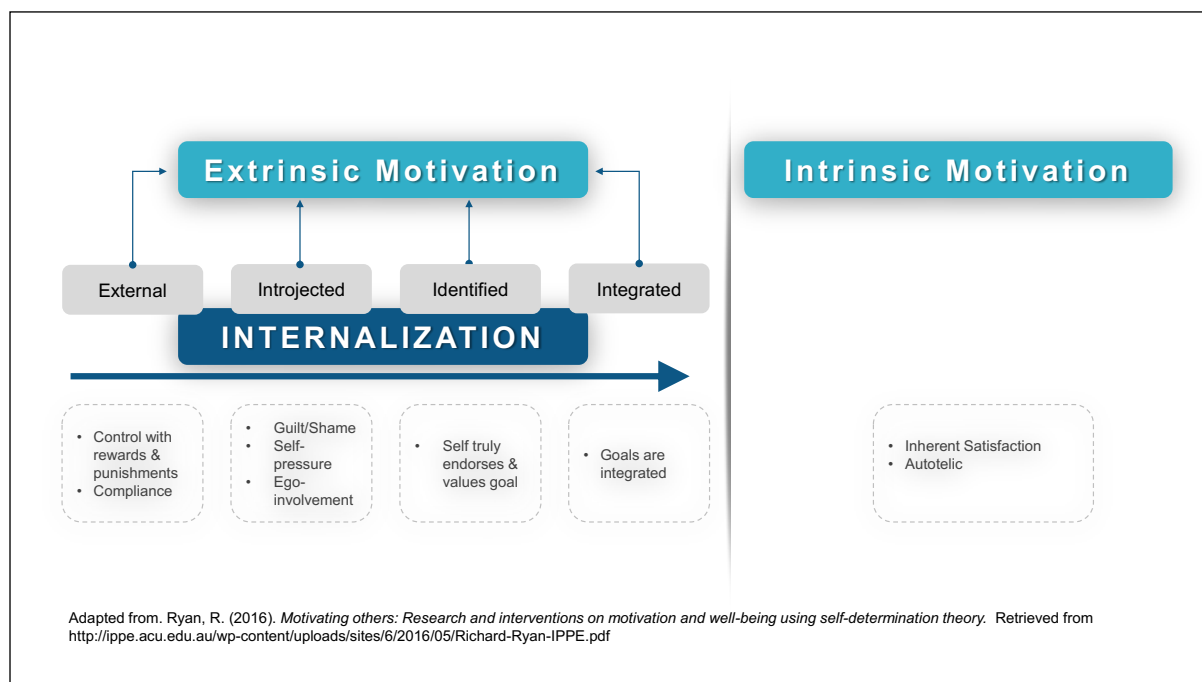


Figure 3.23. Slide 23.

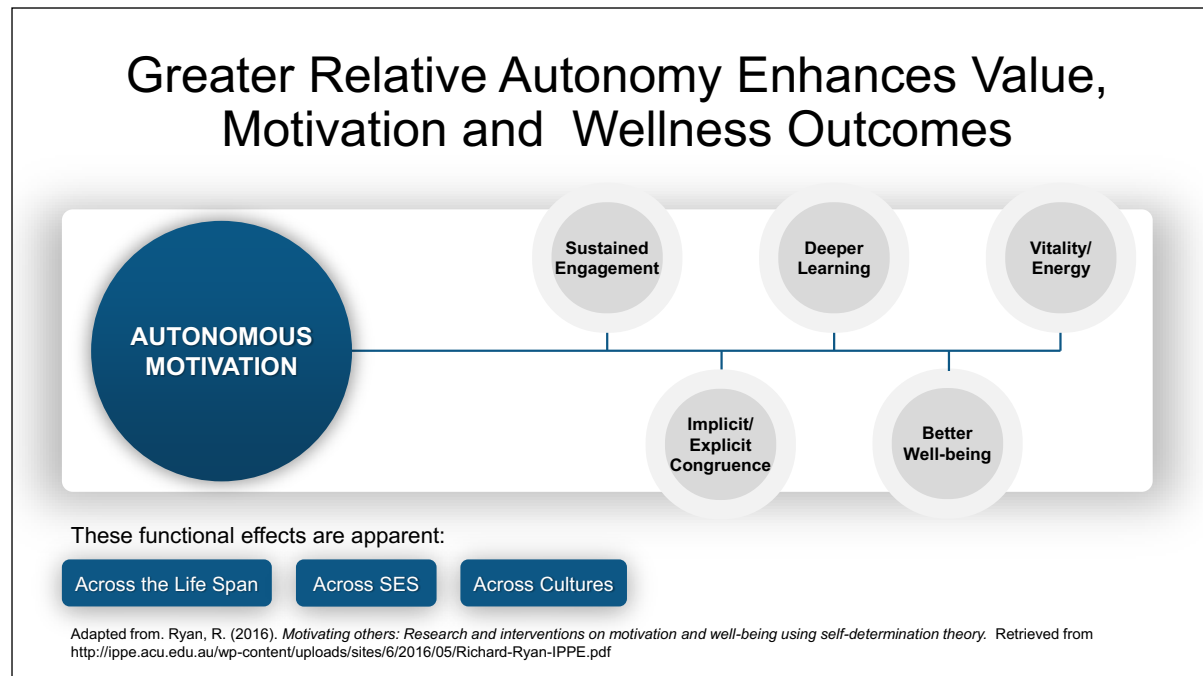


Figure 3.24. Slide 24.

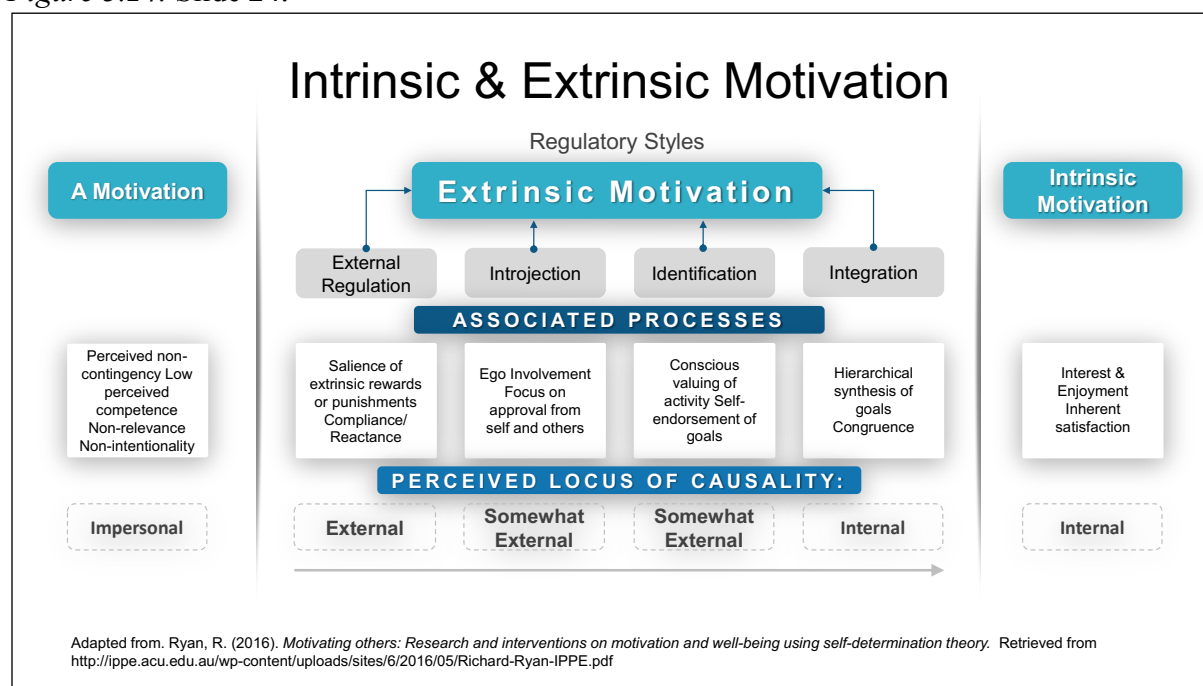


Figure 3.25. Slide 25.

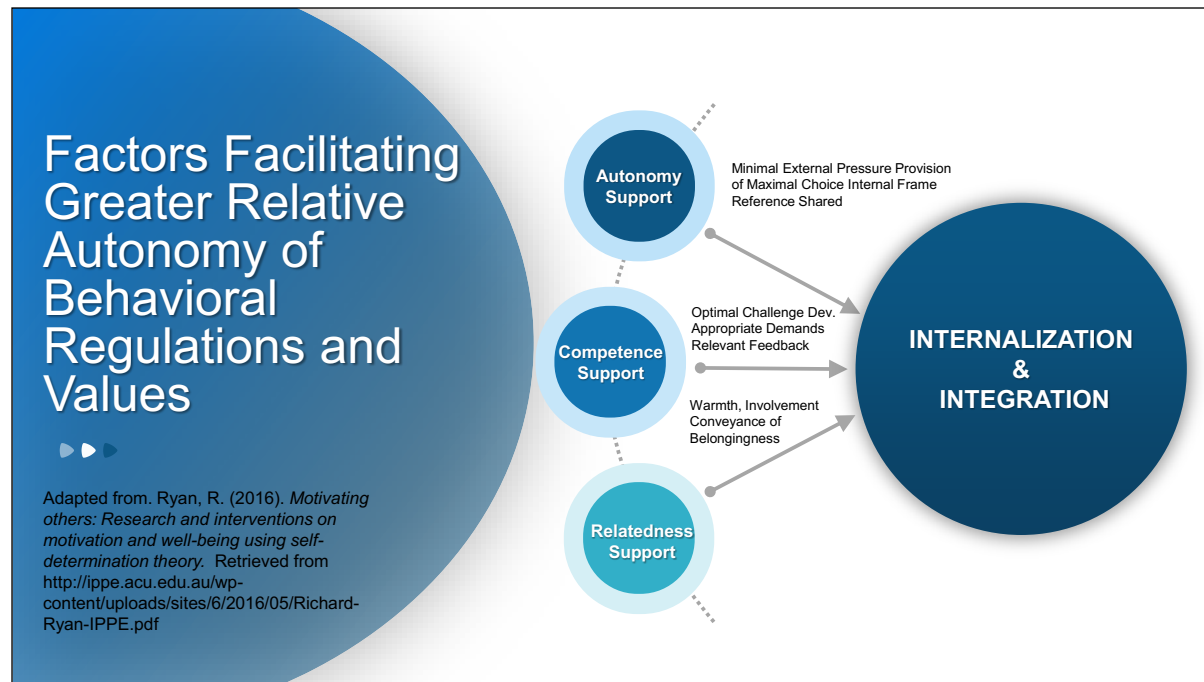


Figure 3.26. Slide 26.

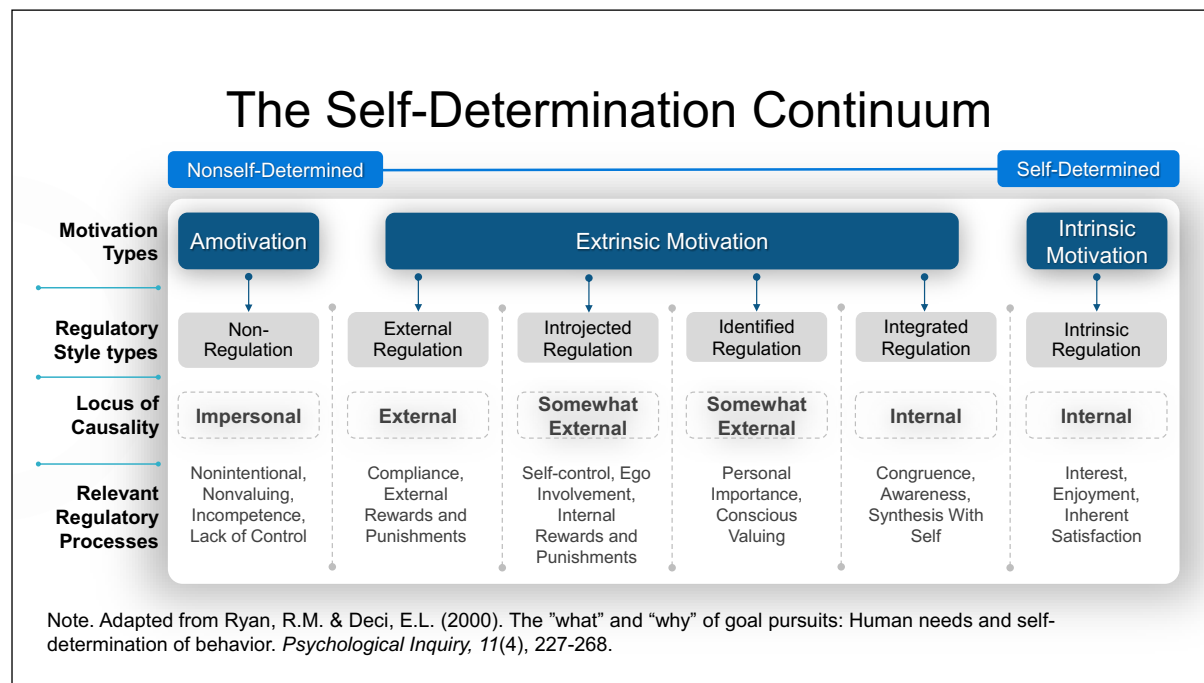


Figure 3.27. Slide 27.

Findings from empirical research and areas for future research: Slides 30--34. The last four slides of the presentation describe the relevance and importance of SDT to support effective social work practices among clients with complex needs. A review of how ACT and FACT staff are challenged to utilize creative interventions among individuals who often have little insight or motivation and are not engaged with treatment provided a useful means to introduce how SDT can implemented in ways that continue to support a person's self-determination.

Three slides were devoted to a brief review of this author's empirical research pilot study of 10 ACT/FACT participants as a means to demonstrate the connection between SDT's basic psychological needs and level of client satisfaction. Descriptive data and results of statistical analysis were examined and explained to show an association between autonomy, competence, and relatedness and client satisfaction with a statistically significant connection between relatedness and client satisfaction. Areas of future research presented the opportunity to evaluate how integration of SDT into ACT and FACT fidelity instruments could strengthen approaches of autonomy and self-determination and avoid interventions associated with coercive practices.

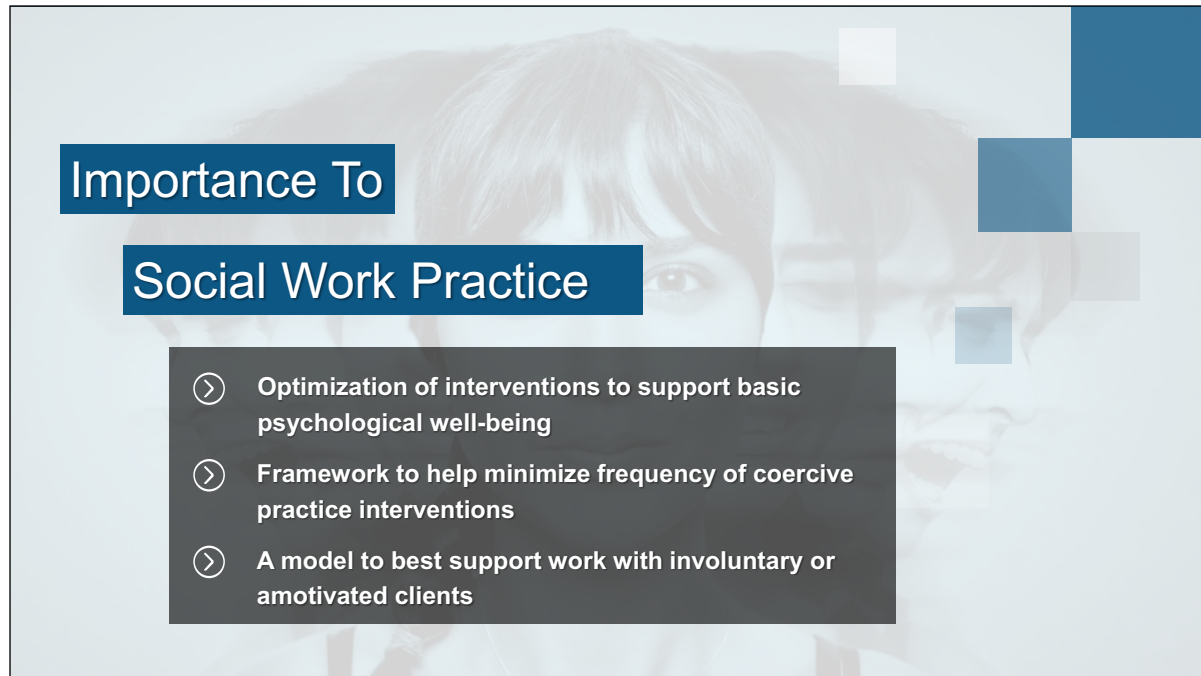


Figure 3.28. Slide 28.



Figure 3.29. Slide 29.

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Descriptive Data

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Table 1

DESCRIPTIVE STATISTICS FOR ALL VARIABLES		
Variable	M	SD
Education	11.83	1.91
Age	44.13	14.53
Years on ACT team	4.68	3.87
Satisfaction	27.07	4.30
Autonomy	5.09	1.06
Competence	4.99	1.03
Relatedness	5.27	1.00

Figure 3.30. Slide 30.

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Satisfaction of Basic Psychological Needs: A Pilot Study

▶ ▶ ▶

Table 2

BIVARIATE ASSOCIATIONS BETWEEN INDEPENDENT AND DEPENDENT VARIABLES			
Variable	(1)	(2)	(3)
(1) Satisfaction			
(2) Autonomy	.12 [-.26, .38]		
(3) Competence	.24 [-.13, .62]	.63* [.23, .93]	
(4) Relatedness	.47* [.13, .81]	.66* [.37, .95]	.59* [.27, .90]

Note. Brackets represent 95% confidence intervals.
* $p < .05$.

Figure 3.31. Slide 31.

Areas of Future Research



- ④ Integration of SDT into ACT and FACT fidelity instruments, training programs, social work curriculum
- ④ Empirical research with larger sample sizes with persons in justice-involved community
- ④ SDT as framework to guide EST practice interventions
- ④ SDT to promote strength-based recovery orientation in practice environments
- ④ Framework to guide partnerships with the criminal justice community and FACT

Figure 3.32. Slide 32.